REPORT OF

THE OCCUPATIONAL DISEASE

TASK FORCE

SUBMITTED TO THE ONTARIO MINISTER OF LABOUR
TORONTO, ONTARIO
MARCH 1993

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March 22, 1993.

The Honourable Bob McKenzie
Minister of Labour
Office of the Ministry of Labour
400 University Ave.
Toronto, Ontario
M7A 1T7

Dear Mr. McKenzie:

We are pleased to submit this Report of the Task Force on Occupational Disease. Our inquiry has been conducted in accordance with the terms of reference provided to us in August, 1991.

The report is a long one. It was clear from the outset that the mandate was broad and the subject complex. In order to provide a full picture of the problems associated with the compensation and identification of occupational disease, we reviewed several related and overlapping areas. Ultimately, in accordance with our mandate, we have made 54 recommendations with a view to improving the present state of occupational disease compensation. We focussed particularly on ways to enhance and strenghthen the adjudication process as it is central to the problem. At the very core of the issues we examined is the dignity of the workers of Ontario. It was our overall goal to find ways to make the system fairer, more efficient and more open.

We have, therefore, consulted widely with the various individuals, groups and government and WCB units that are involved and will be affected by our report. Without exception, we have enjoyed the full cooperation and support of everyone we contacted and we wish to express our appreciation and gratitude for all who so conscientiously responded to our requests for information and advice. In particular, we wish to thank Dr. David Muir who served as special medical advisor to the Task Force.

Finally, the Task Force owes a tremendous debt of gratitude to Dr. Penny Chan who was our research coordinator. Her untiring dedication to the task, her wealth of knowledge in the area and her hard work facilitated every aspect of this report.

Yours sincerely,

Leigh West

Leigh West, Chair

Andrew King

Andy King

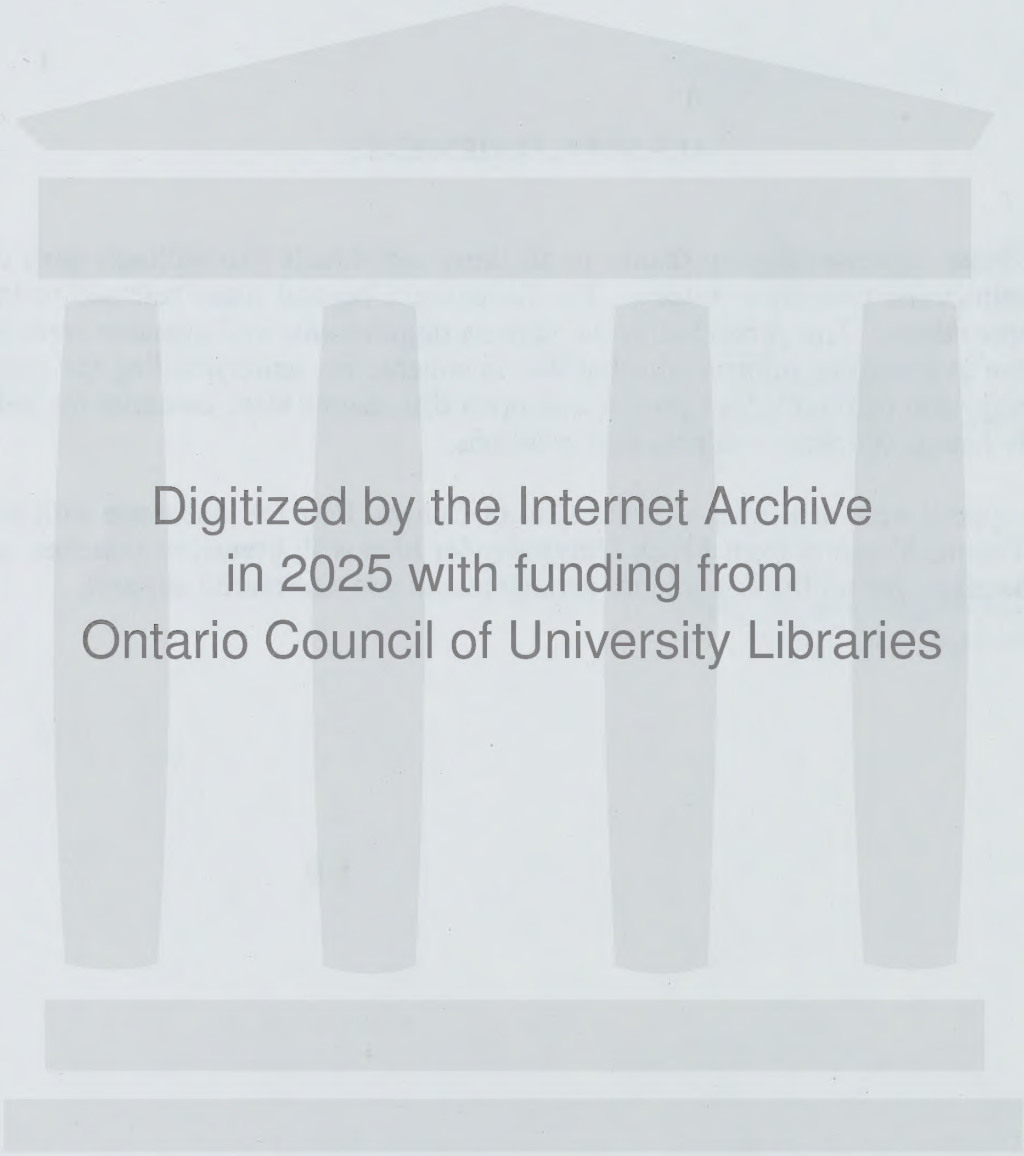
Roger Rickwood

Roger Rickwood

ACKNOWLEDGEMENTS

The task force expresses sincere thanks to all those individuals that willingly gave their time to help in the task force process. The list extends beyond those referred to in the various appendices. The personnel in the various departments and agencies were most cooperative in providing information that was invaluable for understanding the system. The participation of stakeholder groups and open discussions were essential for helping to identify issues, concerns and potential solutions.

Finally a special note of thanks to Lydia Gao of Canada Post for assistance with the Figures, Dennis Shannon from Brock University for help with literature searches, and Regina Banagao for all the last minute arrangements and secretarial support.



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EXECUTIVE SUMMARY
and
RECOMMENDATIONS

The task force's mandate was to examine the principles underlying the adjudication of occupational and industrial disease claims. The approach taken was to

- understand the workers' compensation system and its components
- examine the legislation
- review the process used in adjudication
- identify the information sources and policies available to adjudicators
- identify the issues and difficulties
- recommend changes to facilitate adjudication.

The first part of the document contains a description of the task force's mandate and process. This is followed by a lengthy background containing a brief description of the components of the system and some of the issues and concerns.

The second part of the document outlines the conceptual framework developed by the task force and used as a basis for the analysis of the system.

The following concepts were elucidated.

- **The existing legislation defines entitlement for workers' compensation.**
- **Rather than a clear distinction between injury and disease there is a continuum of medical conditions that reflect different mechanisms of action and other characteristics of the "injuring process".**
- **The causal relationship is described in different ways depending on the mechanism of action by which the illness/disease occurs, e.g. trauma, trigger, aggravation, precursor, cumulative exposure or multifactorial.**
- **Medicine, science and law all play a role in the adjudication of claims, but they have different roles and limitations.**
  - **The role of medicine is to establish the diagnosis of the illness/disease from which the worker suffers .**
  - **Role of science is to identify technical information that may be relevant to causation and opinions why. This includes exposure evaluations and interpretations (including reasons and limitations) of group data and other relevant information indicating association between work and disease.**
  - **The role of law is to structure decision making (weight and relevance of evidence) and to evaluate it according to the legal principles of causation.**

- **The structure of the Workers' Compensation Board (WCB) must recognize, support and reinforce the role of adjudicators in decision making.**
- **Causation is established when it is shown, on the balance of probabilities, that work made a significant contribution to the illness.**

The third part of the document contains the analysis, and is divided into sections according to the components of the system. Each section contains a description of the present system, the concerns, the task force's analysis, what is needed and recommendations for change.

A. THE LEGISLATIVE BASIS AND WHAT IS INCLUDED AS INDUSTRIAL DISEASE

Following a description of the provisions that are relevant to the adjudication of industrial diseases, this section is divided into several subsections.

1. The Purpose of the Act

The wording of the Act and the common law interpretations are examined. It is concluded that **the intent of the Act is to provide a no fault insurance scheme funded by employers to provide compensation for injuries and illnesses when work or work factors made a significant contribution to the development of the injury or illness.**

As there appears to be confusion about the purpose and intent of the Act, the task force considers it imperative that it be made clear to all parties what is covered.

Recommendations

#1 that the Minister of Labour ensure that the purpose and intent of the legislation are clear, and, to achieve this, serious consideration should be given to including, in the legislation, a statement of purpose and intent either as a preamble or as an initial section on intent.

#2 that the Board of Directors of the WCB ensure that the purpose and intent of the legislation are clearly communicated and that this intent is used as the basis for the guiding principles developed and used by the WCB in administering the Act.

2. Provisions for Industrial Disease

The provisions for industrial disease are examined and compared with the provisions for injuries. The reasons and relevance of the differences were considered.

The task force concluded that

- the main reason for the distinction in the Act is evidentiary, i.e. it is usually more difficult to show/prove that diseases are caused by work, therefore,
- the different provisions are to facilitate the process of gathering sufficient evidence to determine a causal relationship to work, eg to allow for the use of group data. Group data identifying a relationship between a disease and work or a work factor(s) can be used to draw inferences about the risk to individuals (thus identifying industrial diseases). If the evidence from such group data is strong enough, it can be used as a basis for a presumption, i.e. that a disease in workers exposed to the work or work factor is due to the work and therefore is eligible for compensation (thus identifying diseases for schedules),
- other differences are to make allowance for the fact that
  . for many diseases there can be multiple possible causes
  . diseases may have long latencies or be slowly progressive
  . many diseases result from extended or cumulative exposures that may involve more than one employer or employment,
- the characteristics necessitating these differences, although more common in diseases, are not true for all diseases and are often found in 'injuries'.

Key issue

- schedules and, to a lesser extent, the definition of industrial disease allow for the use of group data.

a) Definition of 'industrial disease'

Important issues considered

- the reasons and difficulties distinguishing, for the purposes of compensation, between diseases and 'injury by accident',
- how to deal with diseases that have, or <u>can</u> have, many causes only some of which can be related to work. When are such multicausal diseases 'industrial diseases'?
- Is 'industrial' too narrow? Is 'occupational' disease more appropriate?

Key issue

- the characteristics used to distinguish medical conditions that could result from work exist on a continuum (see Figure 4).

Recommendation

#3 that all reference to 'industrial' disease in the Act, policies and guidelines be changed to 'occupational' disease.

Other recommendations for this section follow a discussion of the reasons and needs for a distinction between injuries and diseases. The goal was to find the best means of

clarifying that all medical conditions that cause a worker to be disabled or impaired are compensable under the Act if work made a significant contribution to the development of the medical condition. While clarifying that all such conditions are compensable, there needs to be provision for different means of determining 'work-relatedness' and different presumptions for conditions with different characteristics.

b) Schedules

There is a discussion of the advantages and disadvantages of schedules as well as the problems with the present schedules.

Recommendations

#4 that Schedule 3 be reviewed and updated and that the body responsible for policy development[1] be responsible for recommending amendments, as needed, to keep it up to date.

#5 that all diseases for which the data are of sufficient quality[2] to allow for a presumption of work relatedness under specified conditions be added to the schedule.

#6 that guidelines be developed for diseases on the schedule, indicating the information available on the strength, conditions and limitations of the association to work, to provide guidance for situations when the presumption could be rebutted.

There is a description of how and when such information should be used to determine whether the presumption can be rebutted. There is emphasis on the importance of knowledge of the mechanism(s) of action of the causal agents for specific diseases.

---

[1] The body responsible for policy development is discussed in the section on policy development

[2] The factors to be considered in deciding whether the information is sufficient and of sufficient quality for a presumption are discussed in the text of the document.

#7 that the provision for Schedule 4 with an irrebuttable presumption be repealed.

It is clarified that there will be cases where, when the association is so strong (and indicated in the accompanying guidelines), the presumption within Schedule 3 will be, in fact, irrebuttable.

3. The Need for a Distinction Between Injuries and Diseases

This section builds on the previous sections.

Important issue considered

- there is an overlap in characteristics commonly used to distinguish injuries from diseases (Figure 4).

Recommendations

#8 that the Minister of Labour clarify the Act by

- **having one definition of 'medical conditions that are eligible for compensation', meaning any condition that causes a worker to be impaired or disabled if work made a significant contribution to the development of the condition. The definition should be in one section and contain**
  1) **sudden onset conditions, which include the injuries presently covered in the first two subsections of the definition of 'accident', and**
  2) **progressive onset conditions, which include 'disablements' and occupational diseases;**
- **including all the presumptions and requirements for determining causal relationships together in one section of the Act.**

Progressive onset conditions include diseases and disablements that can be grouped (not separated) according to differences in process for determining the causal association to work. For instance, cumulative conditions (e.g. disablements, chronic poisonings, precursor conditions, sensitivities) where the causal agent and/or the mechanism of action are known and the causal relationship to work can be demonstrated by determining the worker's exposure. Another group would be diseases for which the causal agent has not been determined and/or the mechanism of action is not known. This will include many cancers where group data indicate an association to a particular type of work or work environment, but specific 'cause(s)' cannot be identified. Within this group there will be cases where the evidence of a causal association is sufficiently strong (with or without an understanding of the causal agent or mechanism of action) that the group data can be generalized and diseases can be scheduled.

It should also be clarified that the purpose for the categories is to facilitate the determination of a causal relationship to work, and the provisions and presumptions that apply.

For example, 'arising out of' or 'in the course of' presumption applies to the first part - sudden onset conditions. For disablements there is the requirement for 'arising out of and in the course of' (i.e. no presumption), while for occupational disease there is provision for a schedule with a rebuttable presumption and there is the requirement for diseases not on the schedule to be 'due to the nature of any employment'. The provisions for differences in funding for progressive onset conditions in the second part of the definition should also be dealt with together in the same part of the Act. The distinction between disablements and occupational disease should not be 'exclusionary'. The continuum of conditions diagrammatically represented in Figure 4, must be recognized. If such an amendment is made, section 134 would be redundant and should be repealed.

#9 that section 134 be reviewed and the subsections that are out of date, those that are redundant and those that are never used be repealed.

The amendments are recommended not to change the Act but to update it, make it clearer and easier to administer, and to remove sections that are redundant or unnecessary. The task force also considered it important to point out that the changes to the definition will neither significantly expand nor decrease the number or type of conditions that are eligible for compensation, just clarify the scope.

B. IDENTIFICATION OF OCCUPATIONAL DISEASE

1. Recognition of Occupational Disease by Workers, Employers and Physicians

The importance of this aspect of identification is emphasized.

Important issue considered

- the approach should be towards prevention, early detection and early intervention to reduce the number and severity of the medical conditions caused by work.

Recommendations

#10 that the WCB initiate an active communication and education campaign to increase awareness of occupational disease (the effect work can have on development of disease).

#11 that the WCB, through its policy mailings, provide more information on occupational diseases, how they are recognized and how and when claims should be submitted.

#12 that the Minister of Labour and the Board of Directors co-ordinate efforts with other ministries, including Education, and Colleges and Universities, to increase the awareness and knowledge base of training physicians, other health care professionals and occupational hygienists on issues of occupational health and disease.

2. Recognition of Occupational Disease by WCB

a) Research

There is a description of the present system of identifying occupational diseases in Ontario including the arrangements for research, the types of research and the manner in which the WCB accesses the information.

Key issues

- the focus for research should always be prevention,
- the research needed to identify occupational disease for compensation purposes is the same as that needed for occupational health.

The need for change in this area is overwhelming. There is need for communication, co-ordination, centralization and focusing of the research to reduce duplication and rationalize costs. Mechanisms are needed for determining priorities and ensuring appropriate peer reviews and quality assurance. As the proposals for change are dependent upon the purpose and need for the research, the recommendations follow the section on policy development (section C).

b) Collection and collation of statistics

There is a description of the present system for collecting statistics, the difficulties and an analysis of the reasons for the problems.

Key issue

- standardization of coding, centralization and an understanding of the information being sought are essential for the collection of statistics that are meaningful for analysis.

Recommendations

#13 that a committee be established to determine the specific needs for data bases like Occupational Disease Information Surveillance System (ODISS). The committee should include a member from the Industrial Disease Standards Panel (IDSP), the adjudication unit of the WCB, the corporate data section of the WCB, the policy body for research, a biostatistician from an academic institution, a member representing labour and one representing management.

#14 that the committee (recommended in #13) have a time limited mandate to recommend structure and content of the information to be collected for the ODISS data base to ensure its usefulness for analysis.

#15 that the Minister of Labour and the WCB continue to promote national initiatives towards standardizing the coding system for occupational diseases.

#16 that physicians be required to identify all occupational disease cases on their Ontario Health Insurance Plan (OHIP) billings and that the WCB establish a registry of occupational diseases from this information.

This registry should be separate from ODISS and be derived from bills for service by physicians (to OHIP) that are reimbursed by the WCB.

C. POLICY DEVELOPMENT

Two types of policies are described: general guiding principles and specific policies.

1. General Guiding Principles

Clearly defined guiding principles to direct interpretation of the Act are essential. The purpose is fundamental to implementation of the Act - to aid adjudicators in making decisions on entitlement. The types of issues to be covered are listed and are included with the recommendations under adjudication.

Key Issues

- guiding principles have to be consistent with the Act,
- the mechanism for setting policy direction (guiding principles) has to accommodate the needs and interests of the affected parties and be practical and accountable,
- the Board of Directors must have the ultimate say in policy direction.

Recommendations

#17 that the Board of Directors, in consultation with the body responsible for developing policy,[3] develop guiding principles for the adjudication of occupational disease claims.

#18 that the WCB ensures that the guiding principles be simply and clearly specified and communicated to adjudicators and clients of the system.

2. Specific Policies

There is an examination of the means of developing policy and of the organizations involved, with special emphasis on the history and mandate of the Industrial Disease Standards Panel (IDSP). The list of concerns and the analysis deal with both the purpose and nature of policies as well as with the mechanism of policy development.

Important issues considered

- the purpose of specific policies is to aid adjudicators in making decisions on entitlement that are fair, timely and consistent with the Act,
- policies do not determine what is compensable and what is not. They provide information to adjudicators on the evidence linking particular medical conditions with particular work (factors), which has to be considered along with the specifics of individual cases,
- specific policies have to be consistent with the guiding principles and be based on critical analysis of the best information available, with adequate opportunity for input from affected parties,
- a mechanism and criteria to set priorities for policy development are needed,
- due to the uncertainty about the scientific information on causation and to the number of confounding factors that need to be considered, policies are largely public policy decisions. They have to be based on the best scientific information available and take account of social dimensions and the needs of adjudicators faced with making a legal decision consistent with the Act,
- the body responsible for developing policy has to have the capability to assess the scientific information available and to make public policy decisions as well as have credibility with the WCB, the affected parties and scientific/medical communities,
- the importance of both reactive and proactive policy development.

[3] The body responsible for developing policy will be discussed in the next subsection

Recommendations regarding the IDSP

#19 that the IDSP have an advisory role to the Board on the nature and content of the guiding principles for occupational disease adjudication.

#20 that it be clarified that the IDSP has the mandate to
- **review and advise on updating Schedule 3 on an ongoing basis,**
- **develop specific policies for occupational diseases,**
- **Gazette proposed policies along with rationale,**
- **consider input from affected parties and make changes as appropriate.**

#21 that the IDSP be made responsible for the quality of the information and interpretations used as the basis for the policies.

#22 that there be direct links with the WCB to ensure that the concerns of the Board and the needs of the adjudicators are taken into consideration in the process of, and in setting priorities for, policy development.

#23 that the IDSP have a full-time executive consisting of a neutral chair, a vice-chair representing labour and a vice-chair representing employers, and part-time members with expertise in the relevant technical specialties that are acceptable to employers and labour.

#24 that it be clearly stated that the role of the WCB in approving or rejecting the policies developed by the IDSP be that of a governing body with ultimate accountability.

The Board of Directors of the WCB needs to ensure that the policies are consistent with the policy directions that it has established. However, it should not have a policy department to review the scientific bases or the decision-making process. If there is not a level of trust in the quality and fairness of the policies, there is no point in continuing to have the IDSP perform these functions, and the Act should be amended accordingly.

#25 that there be a requirement for the WCB to publish its response to the IDSP's recommendations along with a time frame for implementation or reasons why it does not intend to implement the recommendations.

The role of the IDSP in both reactive and proactive policy development is described along with the importance of guidelines developed by adjudicators.

Model for Integrating Research and Policy Formation

The model proposed by the task force to integrate the functions of the various organizations and agencies involved in research and policy formation is illustrated in Figure 5.

Recommendations for an integrated system of research and policy formation

#26 that an occupational health research centre be established.

#27 that the functions of the centre include co-ordinating primary research, collecting and collating scientific information from published literature and collecting and collating statistics from the various input agencies involved with occupational health and safety and compensation.

#28 that the centre have a scientific secretariat with expertise in, or access to expertise in, epidemiology, toxicology, biostatistics, occupational hygiene, occupational medicine, ergonomics and psycho-social dimensions of health.

The research centre should have close liaison with academic institutions. In order to maintain liaison and high academic standards, it is suggested that the scientific staff be cross-appointed with universities or other centres of relevant expertise. The report identifies the types of links and interactions such a centre should have nationally and internationally and suggests that, in the long term, a national institute should be established.

#29 that the centre have a scientific advisory committee to audit the scientific quality of the work performed and to ensure that studies are thoroughly peer reviewed.

#30 that the centre be governed by a steering committee composed of stakeholder members from the various input agencies, specifically bodies/agencies charged with developing policies for occupational health and for compensation, e.g. the Workplace Health and Safety Agency, the WCB and the IDSP.

#31 that the steering committee be responsible for determining the priorities for the research to be conducted and criteria to be used, but must take into consideration

- **the feasibility of studies, including the ability to answer the questions asked,**
- **the importance of the topic to the health of Ontario workers, and**
- **the likelihood that the results of the study will lead to actions that will improve the health and safety of workers.**

#32 that the steering committee be responsible for the allocation of funds and be accountable to the funding agencies.

#33 that the funding for the centre and the research fund be derived from existing sources of occupational health and compensation research.

These include the money (and resources) from the Ministry of Labour and the WCB that is currently being used to support, directly or indirectly, occupational health and compensation research as well as the grants program currently used for research. There is the suggestion that external funding should be sought from government research agencies and, for specific projects, private sector companies. Special provisions will have to be designed to avoid conflict of interest.

Government and private sector funding should be sought to support the collation of relevant statistics.

The steering committee, faced with a problem/question will have to determine the sort of research needed. It may need scientific or legal literature searched, analyses of statistics, contact with other jurisdictions or, less often, research studies. It is probable that literature searches could/should be done by the individual agency that has the resources and knowledge base. However, for greatest efficiency, such studies should still be co-ordinated through the steering committee. The task force's report also includes a description of

- the co-ordination and type of communications that will facilitate the process and avoid/minimize duplication,
- the factors to be considered in proposals for studies and reports of results, especially the need for clear, understandable language, the need to specify assumptions and limitations and the need for peer review.

Recommendation

#34 that the experiences of occupational health research institutes in other jurisdictions be reviewed prior to finalizing the administrative and organizational details for the research centre, the scientific advisory committee and the steering committee.

However, when the details are worked out and agreed to,

#35 that the contract and memoranda of agreement between the funding agencies and the occupational health research centre clearly specify accountability and responsibilities.

#36 that the research centre have a legislated mandate.

#37 that, at the time Recommendation #26 is implemented, arrangements be made to integrate the functions and personnel of the Ontario Workers' Compensation Institute into the occupational health research centre.

Implementation of this scheme will also require

- legislative amendments,
  i) to clarify the mandate and specify the structure of the IDSP
  ii) to create the research centre and clearly identify its mandate,
- deployment of the expertise presently in the Medical Occupational Disease Policy Branch of the WCB to support functions for the adjudication process,
- integrating the functions and expertise of the health services branch of the Ministry of Labour into the research centre.

D. ADJUDICATION MODEL

There is a description of the present scheme for adjudicating occupational disease claims and the concerns expressed to and by the task force.

In adjudication the issues that have to be considered at the level of an individual claim include:

- evidence that the worker has an impairment or disability (diagnosis),
- evidence that work could have caused the disease,
- evidence on the individual circumstances that influence the likelihood that work did cause the disease,
- how to ascribe weight to evidence in cases of uncertainty,
- the legal test - what constitutes a significant contribution.

Key issues

- **that adjudication is the key function of the compensation system; therefore, the function of all other components should be related back to how it facilitates adjudication; for this reason,**
- **adjudicators should be consulted and should participate in decision making about the system,**
- the importance of Bradford Hill criteria[4] in determining causal relationships,
- mechanisms for structuring decision making depend on the degree of uncertainty in the available information; therefore, the need for a range of mechanisms that includes
  . schedules with a presumption when there is sufficient information and/or statistically significant data to make an association generalizable to exposed individuals even if it is only for certain conditions of exposure. The schedules should be accompanied by guidelines that indicate the conditions under which the presumption of a causal relationship apply. The guidelines should emphasize that when the work conditions do not meet the 'criteria' (noting the

[4] Bradford Hill criteria are a series of factors to be considered when identifying a causal relationship, ie determining whether work (work factors) could cause the disease. The importance and use of these criteria are described in the document.

limitations), cases should be adjudicated on their individual merits on a case-by-case basis.

- policies/guidelines for specific medical conditions that list the available information and limitations,
- general policies and guidelines that identify the process to be used in case-by-case adjudication. These would include guidance on weighing evidence and determining what, 'on the balance of probabilities', constitutes a 'significant contribution' to the development of a disease.

Recommendations

#38 that the Board of Directors of the WCB, in consultation with the IDSP, develop guiding principles for the adjudication of occupational disease claims. The principles have to be consistent with the legislation and should include

- **the role of adjudicators as decision makers,**
- **that decisions have to be made in accordance with the Act,**
- **applicable legal tests, such as, that, on the balance of probabilities, the work made a significant contribution to the development of the disease, and that the benefit of the doubt goes to the worker,**
- **types of evidence that should be considered in determining causal relationships, e.g. that evidence not be restricted to epidemiological data and include consideration of Bradford Hill and other such criteria (see text),**
- **the fact that the purpose of specific policies is to guide adjudicators; they are not binding rules determining entitlement,**
- **type of information to be included in specific policies (see text),**
- **the fact that workers with multifactorial diseases are entitled to compensation if work (work factors) makes a significant contribution to the development of the disease,**
- **the type and level of evidence that will be considered sufficient to schedule a disease (see text),**
- **the fact that policies and scheduling are public policy decisions that, although based on the best scientific information available, need to take into consideration social dimensions,**
- **the basis for determining 'eligibility rules' or criteria, e.g. that criteria <u>not</u> be based on <u>only</u> compensating the excess (see text),**
- **where exposure values or criteria are included in guidelines, their limitations be noted.**

#39 that the guiding principles be simply and clearly specified and communicated to adjudicators.

#40 that, within the adjudication unit, there be personnel with expertise in the fields of law, toxicology and epidemiology (as well as occupational medicine and occupational hygiene) to respond to the needs of adjudicators.

#41 that the personnel with technical/professional expertise supporting adjudicators
- be trained to understand their role in the adjudication process, the needs of adjudicators and the legal tests that the adjudicators have to apply,
- have the responsibility to respond to specific questions from adjudicators. Such responses should help adjudicators determine and understand the weight that should be put on individual pieces of evidence.

#42 that all technical/professional personnel supporting the adjudicators be encouraged to participate in activities to maintain their professional status and upgrade their skills and training on a regular basis.

#43 that resources be directed to developing guidelines to aid adjudicators interpret WCB policies that are developed for injury claims, but that also apply to diseases.

#44 that guidelines for adjudicators be developed with the active participation of adjudicators

#45 that the special training for CCU-D adjudicators be reviewed. The issues to be covered in training include
- basic training in toxicology and mechanisms of disease causation,
- an understanding of the medical terms used, disease categories, etc,
- basis for industrial hygiene assessments, what exposure levels mean and their limitations,
- basic understanding of epidemiology and biostatistics, including the limitations,
- the Act, guiding principles and policies,
- legal standards of proof,
- case law, its interpretation and relevance,
- process of adjudication, and
- other such information thought important by the adjudicators.

#46 that the WCB, through the Association of WCBs, explore the feasibility of standardized basic training for adjudicators and establishing a means of communication between adjudicators in different jurisdictions.

#47 that there be a mechanism developed to ensure that adjudicators are kept up to date on policy development, recent workers compensation decisions, rules of evidence and relevant information from other jurisdictions.

E. FUNDING

There is a description of the present system of funding and cost allocation, and relevant concerns.

Important points considered

- although funding and cost allocation are not, and should not be, of consideration in adjudication, they are a prime concern that is putting pressure on the system, especially on policy development,
- **with increasing scientific understanding of disease causation, more and more diseases can be shown to be associated with work, to a greater or lesser extent,**
- although it appears clear that the interpretation of present legislation is that entitlement is based on work making a significant contribution to the development of the disease, there are more and more of these 'difficult cases', and there is concern that the system cannot afford the costs,
- costs to the worker, the worker's family and society of not compensating for diseases that are related to work,
- the generally high cost of compensation and how to spread the cost of disease claims more fairly, recognizing that not all employers want the present arrangements for allocating costs to change.

Before examining options for different mechanisms for funding the system, the task force identified certain issues in the present system that needed addressing.

Recommendations

#48 that the chair of the WCB develop an agreement with his or her counterparts in other jurisdictions in Canada on cost sharing for claims for occupational diseases with progressive onset or due to cumulative exposure when the exposure history of the worker includes more than one jurisdiction. This issue has to be resolved in such a way that the worker gets full benefit for the work related disability.

#49 that the cost of claims for occupational diseases with progressive onset or due to cumulative exposure not be charged to the accident record of individual employers for the purpose of experience rating and penalty assessments.

#50 that a fairer method of allocating the costs of claims for occupational diseases with progressive onset be found.

A number of alternative methods for funding and their pros and cons are discussed.

1. A separate fund to cover the cost of occupational diseases funded by
   a) a flat rate for all employers in the system,
   b) a percentage of present assessments.

2. An occupational disease fund paid into by all employers.
3. Integrating or supplementing the workers' compensation system with other benefit schemes such as long-term disability plans (public or private).
4. Proportional compensation depending on the proportion of 'work-relatedness'.
5. Universal compensation or comprehensive disability insurance.

Since determining a mechanism for funding the system was not within the task force's mandate and because of the complexity of the issue and the need to consider many factors outside the funding of industrial disease claims, the task force did not come to any conclusions on this matter. Many individuals and groups are calling for a public inquiry or royal commission to examine the workers' compensation system or to explore a system of universal compensation. Some employers are opposed to such an inquiry. The document contains a brief discussion of this issue.

Recommendation

#51 **that a committee with members from the affected parties be established to examine in detail the funding options as outlined in this report, and to recommend to the Minister of Labour and the WCB whether any are acceptable, practical and capable of resolving the issues of cost allocation and funding for occupational disease claims.**

If the committee (referred to in recommendation #51) cannot recommend a satisfactory solution, serious consideration should be given to establishing a royal commission to study the issue of funding the workers' compensation system.

F. REHABILITATION

There is a brief discussion of the present system and concerns relating to rehabilitation for occupational disease claimants.

Important points considered

- rehabilitation is a very important part of the system, both in preventing adverse health effects by removing the worker from conditions that are hazardous to the worker's health and returning the worker to gainful employment and quality of life and in saving the system a great deal of money in long-term benefits,
- sensitivities and asthmas pose different challenges to the system, which need to be specifically addressed.

Recommendations

#52 that there be an active campaign by the WCB to educate workers, employers, physicians, occupational nurses, hygienists and other health care workers about sensitivities, to allow for early detection and prevention, and to alert physicians to the importance of distinguishing between sensitivities and aggravation of symptoms.

#53 that the WCB devote more resources and attention to rehabilitation of occupational disease claimants.

#54 that medical rehabilitation strategies for workers with occupational diseases be reviewed and every effort be made to co-ordinate medical and vocational rehabilitation.

G. OTHER ISSUES

In this section there is a list of other issues brought to the task force's attention. Regionalization is the only one explored in any detail. Discussion of the advantages and disadvantages of regionalization takes into consideration the specific and specialized needs of occupational disease adjudication.

CONCLUSION

The recommendations in this report are directed to improving the present system for adjudication of occupational disease. Many may be considered as short-term solutions and others as initiating moves towards the only long-term solution: prevention. However, the task force was sensitive to criticisms that its work represents a tinkering with a system that is inherently flawed.

In the area of funding, which was beyond the task force's mandate, the task force offers some thoughts on the fundamental issue of how the costs should be allocated noting the importance of considering the total costs, including those to the worker and society. A number of alternatives were described, but the recommendations are limited to minor alterations in the present system.

There needs to be a thorough examination of the issues of funding commencing with those identified in this report. The task force concluded that if the system is still unmanageable after the recommended changes are made, either the whole system has to be changed and new sources of funding found or the Act has to be amended. Amendments to the Act to change its intent would need thorough public debate and the will of the legislature.

Implementation

It should be emphasized that the task force, although recognizing minor problems and some confusion with the Act, anticipates that, if the recommendations contained in its report are implemented as soon as possible, there will be considerable improvements in the effectiveness and efficiency of the present system. These changes will reduce time delays, costs and the number of appeals. The task force proposed a plan to facilitate implementation, and commends it to the minister.

STRUCTURE OF THE REPORT

This report is based on the task force's review of the compensation of industrial disease under the Workers' Compensation Act (WCA). The terms of reference for the task force (Appendix 1) were fairly specific in that they listed: Specific Objectives, Background, Issues, Product, Process and Methodology

> **to examine the principles underlying the approach of the WCB to the adjudication of occupational and industrial disease claims.**

As the task force commenced, it realized that to review, in isolation, a single component of a very complex system is relatively meaningless. The interaction of the components must be understood, and overlapping functions need to be examined. Therefore, the first step was to map out how adjudication fits into the larger picture. This is briefly described in the Introduction. Throughout the process and the report an effort was made to relate everything to the key function - adjudication; how it works, how other components of the system support it, what are the bases for decision making and how the system can be improved so that workers suffering from occupational diseases are identified and eligible for fair compensation under the Act.

The report contains a lot of information that the task force used as a basis for its analysis and deliberations. In many areas this is contained in detailed discussion leading to the recommendations. It is hoped that this information will help the readers understand the task force's rationale for the recommendations as well as the limitations.

It is important to note at the beginning of the report, a view expressed to the task force. The concern was expressed that this report and its recommendations represent a tinkering with the system, which could, in the short term, detract from the thorough investigation needed. The concern was based on the belief that the system was not designed to deal, and cannot deal adequately, with occupational diseases, especially multifactorial diseases. There appears to be growing support for a public inquiry or a royal commission into the whole area of compensation.

However, the task force mandate was to examine the present system and recommend changes where necessary. Hence this was the approach taken. In the section that deals with funding there is discussion of the adequacy of the present system and a list of alternatives. The task force believes that any alternative that involves a major overhaul of the system should not proceed without a very thorough analysis of the implications and careful planning to ensure integration into other systems. Such analyses and decisions to implement major change take many years. In the meantime, there are immediate needs to be addressed, and some of the changes recommended in the document represent steps towards long-term solutions.

The report is divided into four major parts.

I. BACKGROUND, which contains the following sections

A. The task force and its process

B. Introduction and overview of the system

II. DEVELOPMENT OF THE CONCEPTUAL FRAMEWORK

III. ANALYSIS, which is divided into sections according to the main components of the process.

A. The legislative basis and what is included as industrial disease

B. Identification of industrial/occupational disease

C. Policy development

D. Adjudication model

E. Funding

F. Rehabilitation

G. Other issues

IV. CONCLUSION, which contains a short section on implementation.

Each of the sections in the analysis are separated into:
Description of the present system
Concerns
Analysis
What is needed to improve the process, and
Recommendations.

The section on how the system is funded is not and should not be the consideration for adjudication. However, funding is a fundamental component of the compensation system, the source of considerable concern and has stimulated the call for investigation and change.

A number of other components of the system that were not the focus of specific discussion are included only as they relate to the adjudication process of occupational diseases.

These include:

- level or nature of benefits;
- specific diseases or specific criteria, except as examples;
- analysis of service delivery;
- rehabilitation;
- appeals system (other than its affect on policy development);
- level or nature of assessments.

Since many components of the system are discussed in the Analysis, the Introduction contains only a brief description of the system,s major components and their roles. Other issues introduced include diseases compared with injuries; adjudication, the process, information available and the tools, i.e. policies and guidelines; scope of the problem; and funding.

The Development of the Conceptual Framework contains a discussion of the issues in adjudication, the roles of science, medicine and law, and legal issues including standard of proof and case law on causation.

There are areas of overlap between the sections, but an attempt has been made to reduce the duplication as far as possible.

I BACKGROUND

A. THE TASK FORCE AND ITS PROCESS

1. Task Force Mandate and Structure

The Occupational Disease Task Force was established in September 1991. The members (Appendix 2) were appointed by Order in Council. In October 1991 a research co-ordinator was hired. A medical adviser was selected, who aided the task force as needed. The terms of reference presented to the task force by the Minister of Labour were detailed and specific (Appendix 1). Although the objectives covered a range of occupational disease issues, the prime focus for the task force was process, e.g. the adjudication model, how it works, its problems and limitations and means of facilitating it.

2. Task Force Process

The process used by the task force is schematically presented in Figure 1.

The initial phase consisted of information gathering. Information was gathered from all available sources on the present system of adjudicating industrial disease claims in Ontario and how the various components of the system fit together. A broad review of recent initiatives and literature on the topic was also conducted (see attached Bibliography).

The second phase consisted of meetings with individuals from various organizations involved in the process. The task force also convened a round table discussion with technical experts in the fields of industrial hygiene, law and occupational medicine along with representatives of labour and management organizations. The topics for discussion were retrospective exposure assessments and the roles of law and medicine in adjudicating industrial disease claims. A list of participants and a summary of the proceedings are presented in Appendix 3.

Another round table discussion was held in May 1992 with personnel from adjudication units in other Canadian jurisdictions. A questionnaire (Appendix 4) had been circulated to all the jurisdictions in Canada regarding the legislative provisions and the practices for adjudicating occupational disease claims. The responses to the questionnaires were collated and circulated prior to the meeting. The discussion at this second round table focused on the practice, problems and means of dealing with the issues faced by adjudicators. A list of participants and a synopsis of this meeting are presented in Appendix 5. The collated responses to the questionnaire, detailed proceedings of the

meeting and a list of information received from the jurisdictions are appended to the Supplement - Information from Selected Jurisdictions.

Although the employer and labour members of the task force were in constant communication with their constituents, it was decided that task force consultations would be helpful. There was concern that many of the constituent groups might not be familiar with the issues being addressed and, hence, might be reluctant to provide input. However, their opinion was considered essential to help the task force understand the concerns and to help formulate practical solutions. A questionnaire was designed and circulated to occupational physicians and a variety of employers and employer groups. The response rate was encouraging. There were open-ended questions and the assurance that confidentiality would be maintained. The purpose of this 'survey' was to promote discussion and seek opinions. A statistical analysis of the distribution of responses would not have been appropriate. The questionnaire and summaries of the responses are presented in Appendix 6. The task force also met with a variety of employer groups and associations as well as with labour groups, injured workers and worker health clinics. The research co-ordinator met with a number of individuals in the various agencies and departments. Appendix 7 is a list of persons, organizations and associations contacted and meetings attended. The task force was delighted at the co-operation and help it received from all those contacted, and wish to thank everyone for their time and attention.

As a means of ensuring a clear understanding of the adjudication process, the research co-ordinator reviewed some case records. The cases were selected from claims submitted to the Workers' Compensation Board (WCB) in 1991. The cases chosen for review were initially identified by causal agent or disease and included claims for tight environment (sick building syndrome), isocyanate sensitivities and cancer. Cancer cases were selected according to whether or not there were policies or guidelines. Those selected were sinter plant emissions, general lung cancers and skin cancer. Each group contained a cross section of cases that were accepted and denied. A brief summary of the overall findings from this review is presented in Appendix 8.

One of the terms of reference for the task force was to assess and compare the approach to compensating occupational disease in Ontario's workers' compensation system with the methods used in other jurisdictions (OECD member nations). This posed the task force certain problems. Although there is some information in the literature and copies of legislation are available, the task force felt that it could only make a meaningful comparison if it understood the way in which the systems function. From the meetings with representatives from the various Canadian jurisdictions, it was obvious to the task force that even when systems and political climates are quite similar, the way the systems function is largely dependent on the social, political and fiscal situation at the time. With this in mind, the task force decided to gather all the information on the Ontario system and understand its functioning before determining the aspects of other systems to investigate in detail. General information was sought and specific jurisdictions with

different systems were briefly reviewed. The research co-ordinator met with some individuals. A summary of the information gathered is contained in the Supplement. There are some references to other systems in this report, and the task force's understanding of the various alternative systems influenced the analysis and, thus, the recommendations.

The final phase of the task force's work was the analysis of the information and discussions to reach consensus on the most fair, effective and practical means of addressing the issues that had been identified. This phase involved considerable task force discussion, and when a draft of its findings and recommendations was completed, a variety of focus group meetings were held. In these meetings, listed in Appendix 9, the task force presented the major findings and proposed recommendations for discussion and input. The comments and concerns of the various groups were considered and, where possible, addressed. The task force did not call for submissions as the philosophy that dominated the task force's approach was that open discussions are a more meaningful way to involve the different interests and a more useful means of identifying and addressing issues. The response to the focus group meetings was so positive that the task force was requested to convene another meeting. An 'open forum' was held and participants from the focus groups were invited to discuss the several critical issues that had been identified. The attendees and a summary of the proceedings are presented in Appendix 10.

As all parties are well aware, in a complex system it is impossible to find solutions to all the problems that will satisfy all the very diverse interests and concerns.

The following report is the result of discussions amongst the task force members at the end of this process. The task force took pride in the time it spent in its discussions, the open, fair process and the respect that was maintained throughout.

B. INTRODUCTION AND OVERVIEW OF THE SYSTEM

To examine the principles underlying the approach of the Workers' Compensation Board to the adjudication of occupational and industrial disease claims, it is necessary to see how adjudication fits into the whole scheme of workers' compensation and how the various organizations, agencies and panels interact.

Adjudication is the central issue for the workers' compensation system. The rest of the system, its processes and components are examined in light of how they assist adjudicators to make decisions about entitlement, i.e. to determine whether the worker's illness or disease is due to the nature of the worker's employment.

1. Structure of the Workers' Compensation System

Figure 2 is a schematic representation of the major components of the system pertinent to occupational disease adjudication with an indication of the lines of authority and mandate. Figure 3 is a simple flow diagram indicating the interaction of some of the components. A very brief description of the components and their mandate follows. Some of these will be described in greater detail later with an analysis of how the components and their functions fit into the system.

Workers' Compensation Act

The legislative basis for workers' compensation was initially enacted in 1914 and included the provision for compensation of industrial diseases. The Act also identifies the means of collecting the money that pays the compensation as well as the mandate of the Workers' Compensation Board (WCB) to administer the Act. However, as Weiler commented[1]

> Industrial Disease has historically been treated as the legal step child of the workers' compensation regime. Only gradually has this badge of second-class status been removed. Even yet the process is unfinished, as exemplified by the fact that under the current statute the basic condition entitling a person to benefits is a "personal injury by accident arising out of and in the course of employment" (S.3(1)). Industrial diseases have a provision of their own, tucked away at the back of the statute, under which, ironically, a person disabled as a result of the disease is "entitled to compensation as if the disease was a personal injury by accident" (S.122(1)).

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[1] Weiler, Paul C. Protecting the Worker from Disability: Challenges for the Eighties. A report submitted to Russell H. Ramsay, Minister of Labour (Toronto: Ontario Ministry of Labour), April 1983.

The Act was based on Meredith's 1913 report, which contained a draft bill to found an Ontario Workmen's Compensation system based on four principles.

1) The first principle disregarded the question of negligence in its entirety (except where the injury was solely attributable to the serious and wilful misconduct of the worker, and did not result in death or serious disablement).
2) The second principle was that need as a result of the accident was the most important factor. The test for need was based on the worker's inability to earn full wages for more than seven days after the accident.
3) The third principle was that compensation costs rested solely on employers, who were collectively liable (except for railways, publicly owned companies and municipal corporations, who were individually liable). Two schedules set out the classes of employers who were either collectively (Schedule 1) or individually liable (Schedule 2).
4) The fourth principle vested the Act's administration in a three-member commission appointed by the legislature. No appeals or judicial review were to be allowed.

It was considered that employers should pay because they had the greatest ability to pay and they benefitted from the labour of those that were injured. Meredith recognized that the costs would, ultimately, be passed on to the consumers.

The workers' compensation system is considered to represent a historic balancing of the worker's need for assured compensation and the employer's need for predictability and protection from tort liability. It is essentially a no-fault insurance plan. The benefits paid to workers are provided by the WCB and are funded by employers.

There is much current debate about the ability of the system to effectively determine whether or not work played a causal role in the development of a disease. More and more, research is demonstrating how extensively work affects health. When the consequence is disability, who should bear the cost? Many argue that to protect the disabled worker's income, any work contribution should be enough: on the other side, employers argue that the costs are growing too high and they should pay only that which is predominantly due to work. Between these two extremes is the current requirement that work must make at least a significant contribution to the development of the disability. This compromise is at the heart of a system that tries to balance these two views of corporate responsibility for disability. As this is one of the most critical issues underlying the adjudication of occupational disease, these concepts will be developed more fully throughout this report.

There will also be a more detailed discussion of the Act, the history of the provisions for industrial diseases, the legislative basis for adjudication and the issues that it raises. Some other components of the system have a legal mandate under the Act, e.g. the Industrial Disease Standards Panel, the Workers' Compensation Appeals Tribunal, the

Office of the Worker Adviser and the Office of the Employer Adviser. These are all funded directly or indirectly from the administrative fund of the WCB.

Occupational Health and Safety Act

Although peripheral to the adjudication of occupational disease, this Act deals with protection of worker health and safety and investigation and inspection of workplaces. It provides a legal mandate for the Workplace Health and Safety Agency (the Agency) which is responsible for administering education and training in occupational health and safety and the grants program for funding research into occupational health and safety. The education and training programs that used to be the mandate of the safety associations established under s135 of the Workers' Compensation Act (and the Agency) are funded by transfer payments from the WCB, whereas the grants program is from transfer payments from the government. The Ministry of Labour is responsible for administering the Occupational Health and Safety Act and conducts some research and investigations pertinent to its mandate in occupational health and safety.

Workers' Compensation Board (WCB)

The WCB has a number of functions under the Act and a complex and changing organizational structure. The main functions include determination of compensation claims; workers' rehabilitation; determination, collection and investment of employer' assessments; and internal review of Board decisions. The departments directly relevant to the adjudication of occupational disease include the following:

1) The Complex Case Unit - Diseases (CCU-D). This, unlike the units responsible for the adjudication of injury claims, is centralized in Toronto. All disease claims (with the exception of those for noise-induced hearing loss) received at the Integrated Service Units in the regional offices are forwarded to the CCU-D for adjudication
2) The Medical and Occupational Disease Policy Branch (MODP). This was recently established as a branch of the Strategic Policy Analysis Division. Its mandate is to develop, analyse and evaluate policies regarding occupational diseases and medical matters and to provide scientific advice on other policy issues.
3) Consultation Unit. This unit also was recently established under the Strategic Policy Analysis Division. Its function is to co-ordinate consultations with stakeholder groups.
4) Revenue Policy, for development of policies for funding compensation. The means of funding occupational disease claims is very similar to those for funding injury claims.
5) Corporate Data. Recently a separate information system was established for diseases - the Occupational Disease Information Surveillance System (ODISS).

Industrial Disease Standards Panel (IDSP)

The IDSP was established in 1985 following the amendment of the Act in 1984. The membership was specified to include 'persons representative of the public and of the scientific community and technical and professional persons'. Representatives of labour and management are not specified in the legislation, but have always been included on the Panel. The functions specified in s95(8) of the legislation are as follows,

(a) to investigate possible industrial diseases;
(b) to make findings as to whether a probable connection exists between a disease and an industrial process, trade or occupation in Ontario;
(c) to create, develop and revise criteria for the evaluation of claims respecting industrial diseases; and
(d) to advise on eligibility rules regarding compensation for claims respecting industrial diseases.

Workers Compensation Appeals Tribunal

The Workers' Compensation Appeals Tribunal (WCAT), formed in 1985 following an amendment to the Act, is an external tribunal serving as the final course of appeal for decisions, orders or rulings of the Board respecting, among other things, entitlement to compensation or benefits under the Act. When investigating an appeal, WCAT conducts detailed reviews and analyses of the decisions as well as the basis used to make the decision. The reports, which communicate its findings to the Board, contain detailed descriptions of the case and the reasons for the decision. In a number of cases the decision turns on a matter of interpretation of the Act or policies. In these cases there is a detailed analysis of the legislation and its interpretation. The decisions do not set precedents, and the WCAT does not have any direct role in policy development[2]. Its role in the system for determining entitlement for industrial disease claims is one of auditing/reviewing.

Office of the Worker Adviser and Office of the Employer Adviser

These bodies were established in 1985 by amendments to the Act. Although very separate in their structure and functions, their primary mandate is to advise workers or employers on their respective rights and responsibilities under the Workers' Compensation Act. There are advisers in a number of offices across the province as well as a central office that provides some support functions and expertise. The advisers tend to respond to individual requests for assistance in filing, but more commonly appealing, a claim to WCB or WCAT. The offices also collect and disseminate information to their constituents. Recently, they have been granted agency status, which increases their

[2] In the section on Policy there will be further discussion of the role of WCAT and the way its decisions are often perceived as setting precedents and indirectly influencing policy formation.

autonomy and 'distance' from the WCB and government. This allows them to be more active in developing position papers and responding to requests for input on policy proposals from the WCB. They also act as advocates for their constituents, collectively as well as individually. For these reasons, there has been a restructuring to create a line of accountability to the constituents. The Office of the Worker Adviser mostly advises non-unionized workers since unions usually provide this type of support for their members.

Ontario Workers' Compensation Institute (OWCI)

Established in 1990, OWCI does not have a legislated mandate but a contract with the WCB. There are three main responsibilities specified in the contract: 1) to carry out health care research in order to determine effective and efficient methods of health care delivery for individuals with work-related injuries and diseases; 2) to assist in the development of curricula for training health care professionals in new approaches to the medical rehabilitation of injured workers; 3) to develop and operate a comprehensive quality assessment and accreditation program for the community clinics and regional evaluation centres throughout Ontario.

Other components of the system

Other components of the system that play a role in the compensation system include the following:

- Safety associations funded by the WCB under s135 of the Workers' Compensation Act have a mandate for education in accident prevention. Originally, they were formed by employers in a class included in Schedule 1. Gradually, issues of disease prevention and occupational health were considered by the associations as well as safety and accident prevention. In addition to providing education, they also perform investigations and collect and collate information on hazards in particular types of workplaces. They may disseminate WCB statistics relevant to their constituents. With the 1989 amendments to the Occupational Health and Safety Act, these associations are required to be bipartite, with representation from workers in the industry, and are responsible to the Workplace Health and Safety Agency.
- Industry Associations also collect information on relevant hazards, statistics and diseases. In some cases they may be involved in research conducted by some large member industries. As advocates for their members, the associations often research issues of concern and develop position papers as well as respond to policy proposals issued by the WCB.
- Large companies often conduct research to identify hazards and/or investigate the nature of hazards in their workplaces or processes. Sometimes, large companies, either singly or together with unions, conduct epidemiological studies to help identify incidence of disease or illness in workers. Companies that manufacture

chemicals may be involved in extensive safety testing and experimental research, all of which are important for the identification of industrial disease.

- Worker Health and Safety Clinics. There are several clinics across the province that provide services to workers. They, like the safety associations, are responsible to the Workplace Health and Safety Agency; however, their funding comes from transfer payments from the government to the Ministry of Labour. The clinics examine injured workers and provide advice both on work-relatedness and preventive strategies for control. They have industrial hygienists on staff who may perform assessments of workplaces either by site visits if there is agreement of the employer, or by information provided by the worker and/or other available sources regarding the type of processes and substances used. Extensive questionnaires are being developed to be used as a basis for retrospective exposure assessments. The reports from the clinics can be used in WCB claims and appeals.
- University-based resource centres for occupational health and safety. These were established under the grants program of the Ministry of Labour as an information source for workers and employers. However their clients are mostly employers. They also conduct training sessions and perform workplace assessments. The grants program was to help get them established with the intent that they should become self-sufficient by charging companies for the services provided.
- University-based groups involved in teaching and researching issues pertinent to occupational health and safety. Some of these are also funded through the grants program administered by the Workplace Health and Safety Agency.
- Association of Workers' Compensation Boards. This is a forum for personnel and/or board members from the boards across Canada to communicate with one another. It has a small secretariat that organizes an annual meeting, collects information and disseminates it to the various boards.
- Canadian Centre for Occupational Health and Safety. This tripartite national corporation has the mandate to promote health and safety in the workplace and to enhance the physical and mental health of working people. It is a very important national information resource for workers, employers and government. The emphasis is on prevention. The information is mostly on workplace hazards, risk and diseases. The information that is collected and collated is provided in a number of ways:
  - in direct response to inquires
  - in pamphlets and newsletters
  - in training packages
  - through on-line computer data bases
  - by convening interactive seminar series on specific topics.

  However, recent moves by the federal government to stop funding the centre severely threatens its function as a source of unbiased technical information. The requirement to be self-sufficient by selling its services can only discourage its use and reduce the expertise available to collate and interpret information.

- A number of other organizations that play important roles in the system include: unions; legal clinics for injured workers and occupational health and safety: injured workers' networks and advocates; and a variety of employer groups, including the Employers' Council on Workers' Compensation (ECWC) and the Employers Advocacy Council (EAC), which specifically deal with workers' compensation issues.

2. Diseases and injuries

The focus of this report is occupational disease; therefore, key issues are: 'What is a disease?' and, 'How does it differ from an injury?' There is no simple definition of a disease nor of an injury. Medical dictionary definitions indicate that the difference is that an injury is a specific impairment of body structure or function caused by an outside agent or force, which may be physical, chemical, or psychic. A disease is defined as a 'specific state of malfunctioning'.

Generally, it has been considered that injuries result from physical insult to the body (diagnosis), often from a single or definable event (cause), and because the effects are immediately apparent (e.g. falling off a ladder), it is relatively easy to determine a connection/association with work. However, diseases usually refer to physiological changes that lead to effects on body function (diagnosis) where the processes and causes are not immediately apparent. Effects are often not manifest for some period of time; therefore, it is difficult to determine the cause and whether or not there is an association with work.

Therefore, for the purposes of compensation, the difficulties dealing with industrial diseases (compared to injuries) have mainly been attributed to certain characteristics:

1) the difficulty identifying a cause for the development of the disease
2) the long latent period or slow, progressive nature of the onset of symptoms
3) the fact that a number of factors may interact, contribute to the disease, exacerbate the symptoms, or individually cause the identical clinical condition.

Added to these difficulties is considerable uncertainty and debate about which factors actually can cause many diseases. Interactions and mechanisms of action are often not understood. These issues are explored in greater detail later in the report.

3. Adjudication

Adjudication is the process that the WCB uses to determine entitlement for compensation under the Act. Because of certain provisions in the Act, this involves a series of steps including determining whether the worker is covered by the Act; whether the worker worked in Ontario in an industry covered by the Act; the nature and extent of the illness; and whether the worker's illness was caused by or is due to the nature of

the worker's employment. Typically, the determination of causation and association to work are more difficult for diseases than for injuries. For many diseases an association to work cannot be deduced from a description of the disease, the time, place and events leading up to onset, and the nature of employment.

There are added problems when clinically identical diseases can have more than one cause that cannot be distinguished by examining the worker. Also, more than one factor can contribute to the cause of the disease. Therefore, the determination of cause and whether a disease is due to the nature of the employment raises many issues for adjudicators. These are examined in more detail later in the document.

This report is based on the assumption that the function of the workers' compensation system and the interacting components is to provide adjudicators with the best information available, and to help structure the decision-making process to allow for fair, consistent decisions that adhere to the law and policies of the body that is legally accountable.

Adjudication Process

The process for adjudication is schematically represented in Figure 5. This will be discussed and analysed in more detail later in the report. The important features to be considered in this section are the sources of information available to the adjudicator.

Initially, the claim consists, at best, of information on forms (6, 7 & 8) submitted by the worker, the employer and the examining physician, respectively. Further information may be sought from the workplace or workplace parties, and there are field investigators to gather information and make applications for the provision of medical records. This process provides information on work history and diagnosis. If exposure information is insufficient, information may be sought from Ministry of Labour files.

The information about whether the disease could be related to employment comes from a variety of sources. There are schedules of industrial diseases attached to the Act that are linked to certain processes or occupations. There are policies in the Operations Manual and there are general guidelines. If, however, none of these are available for the particular disease, the adjudicator needs further information. Medical advisers and a policy department provide a variety of technical expertise.

4. Structuring Decision Making: Policies and Guidelines

The difficulties determining cause for diseases are noted above and include the time between incident and onset, the non-specific nature of effects and, often, multiple causes

for the same disease. Owing to the nature of diseases and these difficulties,[3] policies or guidelines are needed to aid adjudicators in the decision-making process. Such policies and guidelines have to be based on an analysis of all the available information and be consistent with the legal requirements of the Act. Because of the limited scientific/medical information and the limitations and uncertainty surrounding much of the available information,[4] the process of developing policies needs a delicate mix of scientific expertise and public policy judgements. As in all cases of scientific uncertainty it is important to separate the science from judgement. It is necessary to identify clearly the limitations of the available information, the assumptions that are made and the vested interests. Although based on science, the judgement should be open for discussion and involve a political process. The process is complex and fraught with difficulties.

In the words of the Royal Commission on Asbestos (RCA) summarizing its discussion of the development of guidelines by the WCB, 'the Board's recourse to guidelines as a means of structuring its discretion, however useful, has been informal, internal, unsystematic, and piecemeal, and has done nothing to dispel perceptions of Board arbitrariness.'

It appears that it was in recognition of these difficulties that the establishment of the Industrial Disease Standards Panel (IDSP) was proposed. There is extensive discussion of the history of the IDSP in the section on Policy Development later in the document. However, it is of interest to note here that both the Royal Commission on Asbestos (RCA)[5] and Paul Weiler in his report to the Minister of Labour: Protecting the Worker from Disability: Challenges for the Eighties recommended the establishment of such a body to deal with the difficult issues surrounding occupational disease.

The need for an open process and input from affected parties was emphasized by both Paul Weiler and the RCA, although the means advocated differed. The Royal Commission on Asbestos noted that formulation of advice on industrial disease policy 'is as much a matter of pragmatic judgement as of scientific judgement.'

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[3] To quote Weiler "Few diseases are specifically industrial, in the sense that exposure to a particular process or substance is both necessary and sufficient for the employee to contract the disease"

[4] These issues will be explored more fully in later sections of the report.

[5] Report of The Royal Commission on Matters of Health and Safety Arising from the Use of Asbestos in Ontario. Chairman J. Stefan Dupre. 1984.

5. Identification of Industrial Disease

The IDSP, as part of its mandate, has the function 'to investigate possible industrial diseases'. There is no clear mandate for research. Although there are a number of other bodies and grants, there is no one body with a clear mandate to conduct research into industrial diseases, nor is there any system to co-ordinate initiatives. The Ministry of Labour conducts investigations and studies on workplace health issues. There is a grants program that used to be administered through the Ministry of Labour to aid in research in occupational health and safety. However, this function was transferred to the bipartite Workplace Health and Safety Agency when it was established in 1990. Part of its legislated mandate is 'to provide funding for occupational health and safety research'. Although the Agency's mandate is enshrined in the Occupational Health and Safety Act, funding for the Agency is from the WCB. The Agency is accountable to the Minister of Labour. The Ontario Workers' Compensation Institute, established in 1990, has research as part of its mandate. However, the research is intended to focus on determining effective and efficient methods of medical rehabilitation.

6. Scope of the Problem

From the 1990 statistics published by the WCB, it can be seen that of the 449,562 claims submitted, 184,444 were allowed lost-time claims. Of these 5,595 (three per cent) were for diseases. Table 1 is a breakdown of these by type according to the figures published in the Annual Report.[6]

In 1990 the new ODISS system was established as a means of collecting information on occupational diseases (and fatalities). According to this system there were 4,033 claims for occupational disease registered in 1990. These were broken down into broad diagnostic categories, and the number of cases in each is reproduced as Table 2. The most obvious cause for the discrepancy between the two sets of figures is the means of coding. It can be seen, comparing Table 1 and Table 2, that the conditions included as industrial disease vary tremendously as do the diagnostic categories used. It can also be seen that neither means of coding statistics use or include codes or categories that are consistent with, or allow the identification of, diseases included in the schedule.

It has been noted that 80 per cent of premature deaths are the result of diseases and 95 per cent of the recipients of total disability benefits from the Canada Pension Plan are disabled as a result of disease, not of accidents. This has been taken to suggest that there is gross under-reporting of workplace disease.[7] Other authors have attempted to estimate the scope of the occupational disease problem by estimating a proportion of

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[6] The Workers' Compensation Board of Ontario: Statistical Supplement to Annual Report 1990.

[7] CLC National Policy Position on Workers' Compensation in Canada, 1989.

disease cases that could be expected to be of occupational origin. This is done most commonly for cancer, and the estimates are in the range of four per cent to 20 per cent.[8] According to most estimates there is still a 'gap' between the number of diseases that are thought to be attributable to work and the number that are compensated. The two reasons most commonly cited for this 'gap' are that there is insufficient information available to determine which cases of a multifactorial disease can be attributed to work, and there is a lack of awareness of the possibility of work-relatedness, both by workers and their physicians. Hence, claims are not submitted and the diseases are under-reported.

Although figures vary from one jurisdiction to another, it appears as though most jurisdictions report diseases as constituting about five per cent of the claims submitted. It is of interest to note that in California, following changes in reporting guidelines and elimination of obstacles (and as public knowledge of the links between work exposures and disease increases), there was a significant increase in the number of claims between the years 1977 and 1985. The largest contributor to the increase was claims for mental disorders and anxiety reactions (which, in California, are compensable and included in the statistics as industrial disease). Even so, in 1985 industrial disease claims still accounted for only seven per cent of the claims.

In order to gain a better understanding of the scope and extent of the problem in Ontario, the task force briefly reviewed statistics available from the WCB. However, it became clear that for a variety of reasons, including coding problems, the interpretation of the information would not be straightforward. Therefore, no attempt was made to estimate the magnitude of the 'gap', to confirm or refute previous estimates, to search for trends as a means of identifying specific areas for concern, or to correlate changes in figures to various initiatives by the WCB. It would be of interest to compare the numbers of claims allowed for a particular condition before and after the development of a policy.

The task force recognized the value that such information would have been as background and as an ongoing reference for its analysis. However, because of the difficulties that are discussed later in the report, limited resources, the variety of possible interpretations for the same information and the task force mandate, the task force focused on process issues. It made the assumption that there is a 'gap' and that the magnitude of the problem in Ontario would not be vastly different from other jurisdictions or other estimates.

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[8] For a description of such estimates and how they apply to workers compensation, see Occupational Disease Compensation in California, by Glenn M. Shor, California Policy Seminar Research Report. University of California, 1987.

TABLE 1

Statistics published by the board for 1990

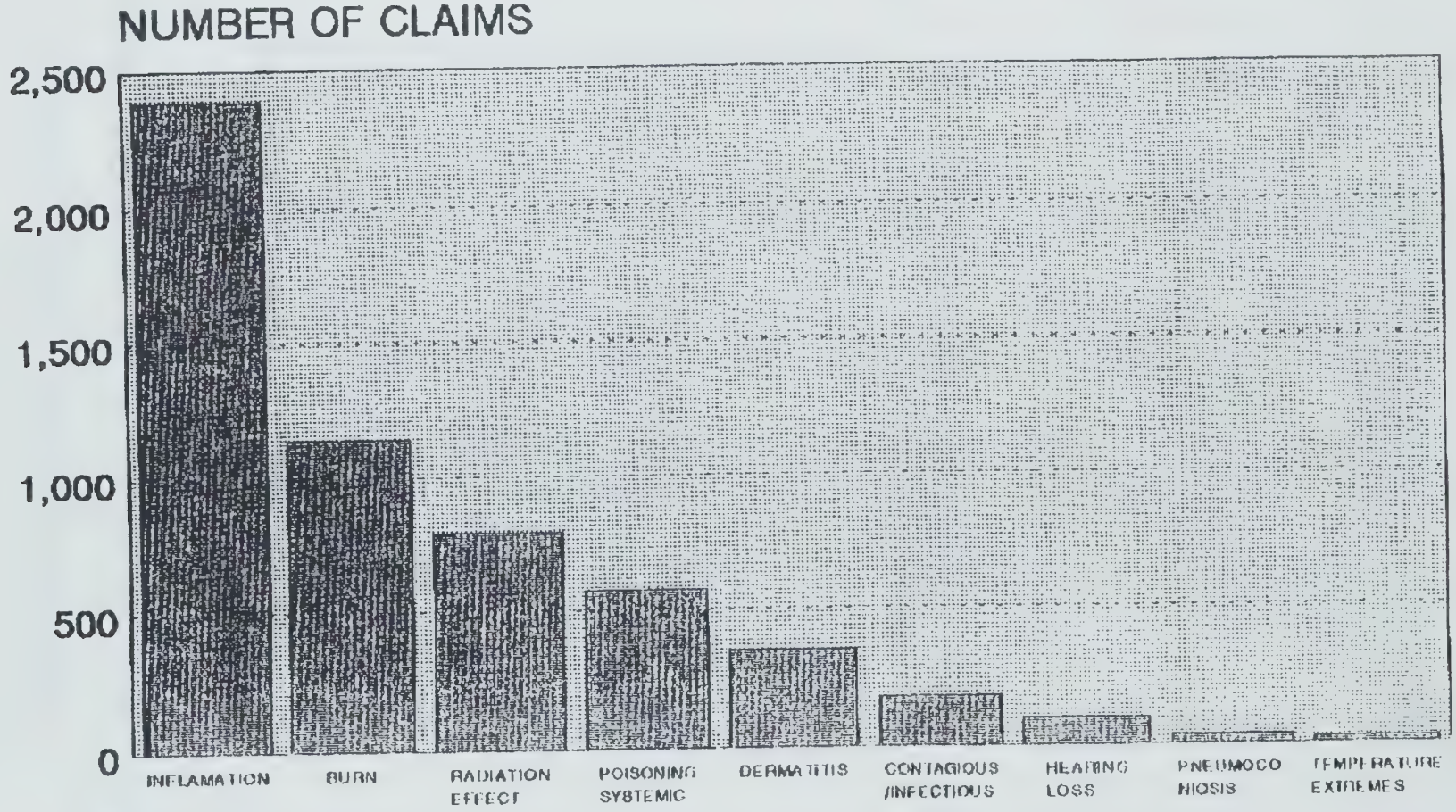
Total claims	**449,562**	
Allowed lost time	184,444	41%
Allowed non lost time	212,436	46%
Not allowed	52,682	12%
abandoned	43,742	10%
denied	8,940	2%

Of the 184,444 lost time claims allowed 5,595 (3%) were for diseases.

The disease claims allowed were divided into the following categories:

Inflamation or irritation of joints, muscles, tendons, nerves and arteries	2,390	42%
Burn	1,145	20%
Radiation effect	794	14%
Poisoning systemic	576	10%
Dermatitis	354	6%
Contagious or infectious disease	183	3%
Hearing loss	101	2%
Pneumoconiosis	32	0.6%
Temperature extremes	20	0.4%
TOTAL	**5,595**	

ONTARIO WCB LOST TIME DISEASE CLAIMS BREAK DOWN BY CATEGORIES



CLAIMS	2,390	1,145	794	576	354	183	101	32	20
%	42	20	14	10	6	3	2	0.6	0.4

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TABLE 2

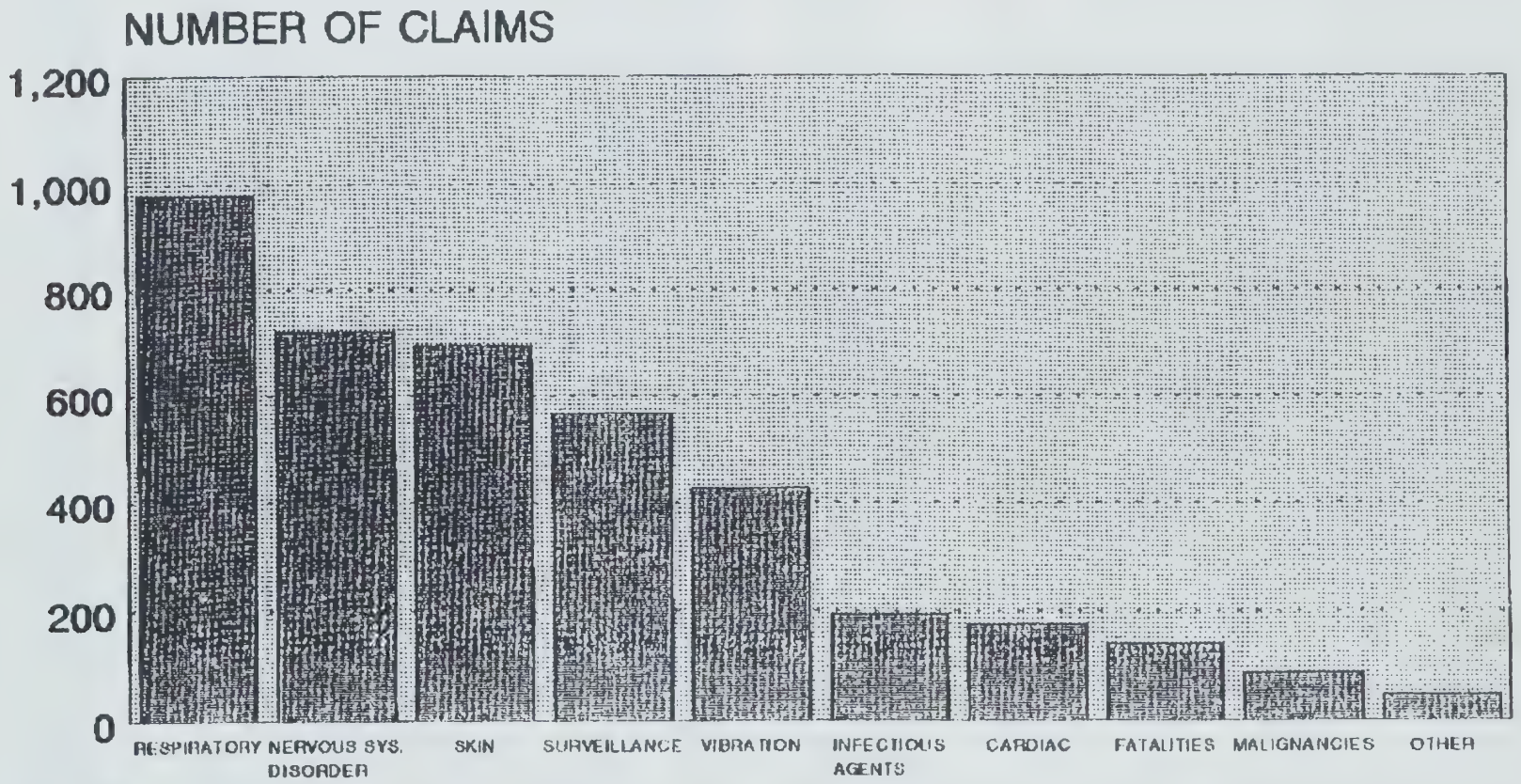
Statistics obtained from ODISS for 1990

There were 4,033 claims registered for disease in 1990. These are divided in the broad diagnostic categories as follows:

Cardiac	176	4%
Fatalities	140	4%
Infectious agents	194	5%
Malignancies	86	2%
Nervous system disorders	721	18%
Other	48	1%
Respiratory	980	24%
Skin	694	17%
Surveillance	566	14%
Vibration	428	11%
TOTAL	**4,033**	

However, using specific diagnostic codes from the same data base, there appeared to be 4,383 claims registered in 1990.

ODISS REGISTERED INDUSTRIAL DISEASE CLAIMS BY DIAGNOSTIC CATEGORIES 1990



CLAIMS	980	721	694	566	428	194	176	140	86	48
%	24	18	17	14	11	5	4	4	2	1

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7. Funding

Although there are provisions in the Act to allow for some differences, the system of funding industrial disease claims has been much the same as the system of funding injury claims.

The differences that evolved in the Act were to address issues such as long latency and gradual onset associated with chronic exposures. However, with an increasing understanding of the mechanisms of disease causation, work factors are being found to contribute to the development of diseases that traditionally have been considered 'diseases of everyday life', or lifestyle diseases. There may be many factors involved in causing the disease or contributing to the cause. This leads to a central issue for adjudication of occupational diseases: if there is a possibility that work contributed to the cause, should there be entitlement to compensation? If so, what 'level' of possibility or probability, what 'degree of certainty' that work contributed and how large a contribution is needed to entitle the worker (or dependents) to compensation?

The task force believed that its task, to review the 'underlying principles' was to identify how these issues are being dealt with at present. For example, the questions asked included 'What degree of possibility?' ' What degree of contribution gets compensated?' 'Are there guiding policies (underlying principles)?' 'Who develops them?' 'On what basis?' 'Are they clearly spelled out for adjudicators?' and 'Are they consistently applied?'

The task force's approach was to analyse the components of the system and their interactions in light of their purpose: to support adjudication and make recommendations to help the system function more effectively and efficiently in a manner that is fair and consistent with the legislation.

II DEVELOPMENT OF THE CONCEPTUAL FRAMEWORK

Adjudication of occupational disease claims by the Workers' Compensation Board was the focus of the task force's work. It would have been ideal to list the issues at the beginning of the report, devote the analysis section to dealing with each issue in turn, and conclude with recommendations for their respective resolutions. Unfortunately, most of the issues are not easily identifiable and emerge only after a detailed examination and analysis of the system and its various components. Hence the issues evolve from and permeate all sections of the document. In this section the fundamental concepts are introduced and developed into the framework that forms the basis for the rest of the analysis.

Adjudication for entitlement to benefits under the Workers' Compensation Act requires a number of steps to determine whether the worker and the industry are covered under the Act, whether there is an illness or injury and whether it is 'caused' by the work. The task force focused on the last step.

The determination of entitlement has to be based on the legislation, and this depends on whether the illness is covered by the definition of injury by accident or industrial disease. As the wording of the Act differs for these two categories (see next section on legislation), there is a need to look at diseases and injuries, what they include and what are the differences.

Concept 1: The existing legislation defines entitlement for workers' compensation

1. Distinction Between Injuries and Diseases

In the introduction the terms 'injury' and 'disease', their common usage and the relative difficulties of determining cause were described. The difficulties in dealing with diseases compared with those in dealing with injuries were listed and attributed to the difficulties determining cause.

However, the lines of distinction between injuries and diseases are not always clear, and there are many factors that make the determination of cause difficult for both. For some injuries as well as diseases, the effects are progressive and the symptoms are a result of, or a culmination of, a series of events or exposures to one agent. In other cases they are due to the interaction of a number of factors/agents or series of events. Not all persons exposed to the same hazard will be affected, and sometimes, even those that are affected may not be affected in the same way. There may be a variety of different mechanisms leading to the disease process, and some 'disease processes' are the

result of a series of physical insults. There are some conditions that are not easy to diagnose and some may have a number of possible causes and manifestations. The determination of causal relationships is very difficult.

In attempting to define the differences between injuries and illnesses and why there is need for a distinction for the purposes of compensation, the task force recognized that there is a continuum of medical conditions that needs to be considered. Many of the characteristics generally associated with diseases can also apply to injuries, and vice versa. The continuum is illustrated in Figure 4. As will be discussed later, the overlap in characteristics probably explains why certain conditions that are not traditionally considered diseases are dealt with as industrial diseases in the Act.

Concept 2. Rather than a clear distinction between injury and disease, there is a continuum of medical conditions that reflects different mechanisms of action and other characteristics of the 'injuring process'.

2. Causal Relationships to Work

Work affects health in many ways, all of which are encompassed by the concept of 'cause' but require differing methods of analysis and evaluation suitable to the mechanisms involved. Conditions can be grouped by the different mechanisms of causation. These are listed below with examples of injuries and diseases that can be included in each group:

1) conditions that are the result of single events or caused by one relatively easy to identify factor (like many injuries by accident, infectious diseases and acute chemical intoxication)
2) conditions which result from chronic exposure to a single substance where the diseases may be slowly progressive with symptoms being related to the extent or intensity of exposure (e.g. repetitive strain injury (rsi), noise-induced hearing loss and chronic lead poisoning)
3) conditions where a work factor aggravates a pre-existing condition (e.g. trauma to a person with degenerative disc disease, and alpha trypsin deficiency, a genetic defect that can potentiate the development of emphysema when there is exposure to certain factors in the workplace)
4) where a work factor triggers an illness that may have been caused by another factor or be an inherent characteristic of an individual (e.g. sensitivities), and
5) multifactorial diseases, where a number of factors can cause the same disease and it is impossible to know whether it was caused by one or a combination of the factors. There are two types of multifactorial diseases:
    a) those in which the effects of the different factors add to the likelihood that the disease will develop, e.g. cancer, and
    b) those in which the factors all contribute to the development of symptoms or to the intensity of the disease, e.g. chronic obstructive lung disease.

Concept 3. The causal relationship is described in different ways depending on the mechanism of action by which the illness/disease occurs, e.g. trauma, trigger, aggravation, precursor, cumulative exposure or multifactorial.

3. Determination of Causal Relationships

Most of the difficulties in adjudication are dependent on determining cause. This is particularly difficult when 1) there is uncertainty about the cause of a condition, or 2) it is known that a particular condition has a number of different causes that may or may not interact, and the interacting factors may be lifestyle or environmental, and some may be work related.

Group data indicating an association between a disease and work (an industrial process, trade or occupation) can not only help indicate which diseases can be considered 'industrial diseases', but also provide evidence that will allow lifestyle factors to be discounted or at least accounted for. In other words, group data can indicate that the association with work occurs in addition to other causative factors.

4. Roles of Different Disciplines in Determining Causal Relationships

Simplistically, decisions about entitlement for compensation are dependent upon a medical diagnosis, scientific evaluation of whether there is a generic relationship between a particular disease and employment, an evaluation of the particular workplace and work history (exposures), weighing the evidence and meeting the requirements of the legislation. The final decision has to be based on legal standards of proof and can be only 'yes' or 'no'. Either the worker is entitled to benefits or is not. Therefore, a mix of legal, scientific and medical issues are involved, and the adjudication process is the crux where they overlap. The task force noted that there seems to be a lot of confusion resulting from the differences between the approaches, the language and the interpretations used by the different disciplines.

To illustrate the differences and the difficulties caused by these differences is the following description of the process of determining the compensability of a disease by determining whether the disease was caused by, or due to, the nature of employment.

The process commences with a claim by a worker who is suffering from an illness that is thought to be associated with work. Usually, there is a diagnosis from an examining physician and often a suggestion or opinion about the cause. The opinion about the cause is usually based on scientific information obtained from the literature or training and from a knowledge of the history obtained from the worker. With a few illnesses there is a great diagnostic specificity in relation to a cause, with others the association is less clear and not identifiable by examining the worker. Generally, physicians focus

more on treatment than cause, and there is concern that general training of physicians in occupational health and diseases is inadequate. Usually, treatment is of the symptoms or the manifestations of the disease and does not/may not depend on cause. In fact, it may even be independent of an exact diagnosis.

Concept 4. The role of medicine is to establish the diagnosis of the illness/disease from which the worker suffers.

The scientific approach to determining causal relationships is based on 'research'. First, there is a search for 'scientific proof' of a causal relationship (i.e. a generic relationship between the disease and a causal agent). Failing this, there tends to be a search for data demonstrating an association between work and a disease. There are a variety of methodologies that can be used, the most commonly accepted are epidemiological studies. However, there are other observational studies, tests about the toxicity of various agents, investigations of biological modes of action and sometimes even 'guesstimates' based on the structure and biological actions of similar agents or structural analogues. Prospective or longitudinal epidemiological studies are the most comprehensive tool but the most difficult to conduct due to time and ethical constrictions of human experimentation. Therefore, even for the best designed and controlled studies, there is a degree of uncertainty associated with the results and the need to rule out many other possible, confounding factors. The data from epidemiological studies may only show an association, which may be 'real' and statistically significant, though it may not mean that there is a causal relationship. For example, there was a classic case of a study that showed a significant association between an increased incidence of cervical cancer in households with outdoor toilets. The explanation put forward was that both variables were associated with a causal factor that was associated with a lower socio-economic status.

Unfortunately, other methodologies are of lesser value for predicting the effect of agents on humans. We are still unable to relate animal studies, let alone in vitro toxicity testing, directly to humans. However, the results of a variety of studies taken together can lead to a varying degree of certainty about an association.

It is common for statisticians to conduct a statistical analysis of the data produced from epidemiological studies to determine the 'significance' of the association. Statistical significance is considered to be when the results indicate that there is a 95 per cent chance that there is a difference between the population studied (the particular cohort) and the general population (or a selected control group that does not have exposure to the work factors or conditions being investigated).

Aside from statistical significance, the data from other scientific studies need to be considered to determine the biological plausibility and consistency of the finding. In other words, it is important to see whether other similar studies have shown similar results, whether there are examples of case studies or reports of clusters, etc. The

interpretation of the findings is usually that, according to the studies, there is a 'quantifiable' probability that the disease is associated with the work rather than the observed association being a result of chance. Alternatively, a conclusion may be that workers exposed to a particular agent or condition at work are at a 'quantifiably' higher risk of a disease. However, the demonstration of a statistically significant association or increased risk to an individual cannot be considered 'scientific proof' that the disease in any one individual in the study population was or was not caused by the work. To a scientist, 'proof' is absolute and rarely attainable. A great deal of the interpretation is also dependent upon what is known about the etiology of the disease; for example, whether one single exposure is sufficient to trigger an event which, many years later, will manifest as a disease, or whether several trigger events are needed at different time intervals, or whether the manifestation of the disease is a result of a 'build up' of a toxic substance in the body and disease will not be manifest until a certain threshold level is reached. There are many other scientific considerations that depend on pharmacokinetics, the ability of the body to clear or metabolize various toxic substances, or the body's ability to repair damage that may be a necessary precursor to the manifestation of a disease.

In cases where the scientific information is complex and ever-changing, it is difficult for an examining physician to have detailed knowledge of all of these areas. As pointed out earlier, rarely is cause the prime consideration for the examining physician who is concerned about providing the best treatment for his or her patient. Therefore, it is important that the adjudicator receive information from scientists about the possibilities of there being a causal relationship, the strength of the possibility, the conditions when it is most likely and when it is unlikely, the reasons and the limitations of the information as well as anything known on etiology of the disease and/or mechanism of action of the causal agent.

As noted above, much of the information on causal relationships is based on group data that is not necessarily generalizable to an individual with the disease. In order to determine the applicability of group data to an individual, there needs to be knowledge of the specific exposures, intensity, duration, interactive factors, work history, etc.

Exposure measurements and work histories involve another branch of science. Usually, such measurements are provided by occupational hygienists or engineers. Detailed exposure measurements are rarely available and in most cases the disease has taken time to develop, and work histories for as long as 20 years may be needed. In many cases, there is not even any knowledge of which substances the worker has been exposed to, let alone the level or nature of the exposures or possible interactions. Data on exposures that are available are often compared to Threshold Limit Values (TLVs), which have been commonly used for enforcement of occupational health and safety rules. The type of information available to an adjudicator may be 'exposures were below the TLVs'. There are serious concerns about the accuracy of testing and the types of workplace monitoring. There are also concerns regarding the data that are used to derive the

TLVs - especially the interpretation that they represent 'safe' levels. Other limitations of exposure measurements that are taken as isolated samples in the workplace include whether monitoring gives any real indication of worker exposure and whether the nature and route of exposure (inhalation, absorption through skin contact as liquids, gases, mists, respirable particles or...) are taken into consideration.

Recognizing that the type of data necessary to prove a causal relationship in humans is almost impossible to obtain, criteria have been developed that take other medical/scientific factors into consideration. Such a set of criteria has been described by Bradford Hill[9]. The nine criteria are those that are commonly used in epidemiology: strength, consistency, specificity, temporality, biological gradient, plausibility, coherence, experiment and analogy (see Endnote 1). Bradford Hill describes the use and limitation of each towards answering the question, 'How do we determine what are physical, chemical and psychological hazards of occupation, and in particular those that are rare and not easily recognized?' Acknowledging that for some diseases the process is relatively simple, 'more often than not we are dependent upon our observation and enumeration of defined events for which we seek antecedents... what circumstances can we pass from this observed association to a verdict of causation?' he concludes,

> Here then are nine different viewpoints from all of which we should study association before we cry causation. What I do not believe - and this has been suggested - is that we can usefully lay down some hard-and-fast rules of evidence that must be obeyed before we accept cause and effect. None of my nine viewpoints can bring indisputable evidence for or against the cause-and-effect hypothesis and none can be required as a sine qua non. What they can do, with greater or less strength, is to help us make up our minds on the fundamental question - is there any other way of explaining the set of facts before us, is there any other answer equally, or more, likely than cause and effect?
>
> Test of Significance
> No formal tests of significance can answer those questions. Such tests can, and should, remind us of the effects that the play of chance can create, and they will instruct us in the likely magnitude of those effects. Beyond that they contribute nothing to the 'proof' of our hypothesis.

Even for these criteria to be applied or, for that matter, epidemiological studies to be performed, there needs to be a distinct endpoint. The endpoint is usually the adverse health effect based on specific medical diagnosis, e.g. cancer. Even though the mechanism of action of causation is not thoroughly understood, there is often a reasonable quantity of information available.

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[9] Bradford Hill, Sir Austin. The Environment and Disease: Association or Causation? Proceedings of the Royal Society of Medicine, v. p.295, 1965

Generally, epidemiological studies use death as the distinct endpoint; these are mortality studies. For obvious reasons, these studies are limited, and more attention should be paid to morbidity studies. Unfortunately, morbidity depends on diagnosis and introduces a number of extra variables and sources of error into the data and the interpretation.

The problems are further exacerbated when the diagnosis is less clear, when there are no specific diagnostic tests, and manifestation of the 'disease'/effect varies among individuals, such as neurological symptoms or 'stress'. Not only are these conditions difficult to diagnose, but studies to identify associations to work factors are very problematic.

The interpretation of the scientific findings are subject to two sets of limitations:

1) methodological, and
2) the relevance of the results to determining
    a) whether there is a causal link between a particular employment (or factor) and a disease and
    b) whether, or to what extent, the disease in the particular worker is likely to be caused by employment.

Concept 5. The role of science is to identify technical information that may be relevant to causation and opinions why. This includes information and interpretations (including reasons and limitations) of exposure evaluations and group data, as well as other relevant information indicating association between work and disease.

All these tools are for the determination of whether a disease <u>can</u> be caused by work.

However, for adjudicators, determining a causal relationship goes further and includes:

1) confirmation of the medical diagnosis
2) evidence that the 'disease' <u>could</u> be caused by a substance/ agent or factor at work
3) evidence that the worker was exposed to a level of the substance or agent for a sufficient length of time to make it possible that the 'disease' in that individual could be caused by his or her particular work, and
4) taking all other factors into consideration, on the balance of probabilities
    - did the disease arise out of and in the course of employment?
    - is the disease in this individual worker due to the nature of the worker's employment or
    - did the employment make a significant contribution to the development or manifestation of the disease?

If, for the sake of simplicity, the adjudication process is broken down into these four steps, it is clear that all the steps involve a degree of judgement. The first is medical, the second is scientific, the third is based on an interpretation of the first two and other information from the specific workplace. The fourth step is clearly legal and involves consideration of all the information.

The Act sets the standards for this decision and specifies the consequence. For example, if the worker is suffering from an industrial disease that can be shown to be due to the nature of the worker's employment, the worker is entitled to benefits under the Act.

Law comprises the rules by which society makes enforceable decisions. In the case of workers' compensation, the law, through legislation and its interpretation, defines the circumstances under which benefits are paid. In addition, the law sets out the rules by which information is evaluated in order to determine whether those circumstances are met. These two functions can be described as substantive rights and adjudicative principles.

Although there has been much controversy over the past decade on what the substantive rule for entitlement is, the question under the present legislation now seems to be settled (see Legal Issues, below). Evidence must establish that the workplace made a significant contribution to the disease. The evaluation and weighing of the evidence remains a source of debate. Some have taken the position that science alone can make the determination whether or not the illness is work related. Others have taken the position that science hardly matters and can be ignored.

The task force believes that the truth lies between these two poles. Science informs the evaluation or weighing of evidence as it relates to the entitlement of benefits, but does not determine it. Law balances the uncertainties and the certainties exposed by science and determines whether or not the legal test for compensation has been met. Clearly, the more certain that science is of a relevant factor for determining compensation, the easier the adjudication can become. But since it is the law that determines the terms under which someone gets paid, legal interpretation identifies whether the information is relevant and how much weight can be given to it.

Finally, it is important to identify that the different disciplines often use the same word in different ways with different assumptions and criteria. For example, some scientists point out that there is no such thing as a 'significant contribution'. Physicians also express concern at what is meant by 'significant contribution' and yet they may be more comfortable using judgement to determine when a possible cause becomes a probable cause. From that scientific perspective this may be correct - epidemiology identifies risks of a consequence, not the cause of a consequence in an individual person. However, from a legal point of view, what matters is the cause of the consequence and not just the risks. In law, just because one risk factor has a greater likelihood than another, it does not, in and of itself, mean that the other risk is not a relevant causal factor. And it is

important to appreciate that this is not due to inadequate legal standards or lower scientific standards; this is a consequence of the limits of science itself. Since science so seldom achieves certainty in terms of causal factors and uses cause often in a very narrow way evaluating only one factor at a time, the decision whether or not there is sufficient information upon which to make a decision of entitlement to benefits must ultimately be a policy incorporated into the law.

It is interesting to note that as science investigates a suspected causal relationship, in many cases, the suspected relationship becomes stronger and not weaker. Throughout this report the task force will be addressing many issues that are focused on this borderline area where science, medicine, exposure information and law connect. The integrity of each discipline has to be respected and demanded, while recognizing the different roles and responsibilities of each.

To a lawyer, proof is when there is sufficient evidence to make a decision. In the case of administrative law, this means whether 'on the balance of probabilities' there is enough evidence to indicate that the disease is due to the nature of the worker's employment. This means that the evidence for there being a relationship is stronger than the evidence indicating that there is not. In other words, it is more probable than not that there is a relationship.

Concept 6. The role of law is to structure decision making (weight and relevance of evidence to) and to evaluate it according to the legal principles of causation.

Concept 7. Medicine, science and law all play a role in the adjudication of claims, but they have different roles and limitations.

5. Role of Adjudicator

Once again considering the four major steps in determining causation, it can be seen that problems in the first part of the sequence include:

- difficulties making a definite diagnosis;
- insufficient scientific data to determine whether a particular disease can be caused by a particular factor;
- lack of or inadequate data/information on work histories and exposure conditions.

Adjudicators get advice from physicians regarding the diagnosis and from scientists (often via policies or guidelines) about whether that particular disease could be associated with work.

With respect to the individual case, there is also advice from a variety of experts. However, considerable judgement is required in the third step in interpreting the results of scientific studies that, at best, will indicate a degree of risk of contracting the disease

as a result of specified conditions in a workplace. Care is needed when interpreting information on the 'degree of risk' derived from group data (applicable to a population) and applying it to an individual. The information is usually expressed as 'probabilities' for individuals. It is dependent on the determination that the conditions at the workplace put the worker at increased risk. The toughest part of the sequence is applying these interpretations to an individual that already has the disease. Is the interpretation that there is a one in 100 chance that this individual's disease is caused by the work, or is this the one individual (in the hundred) that contracted the disease? These difficulties are exacerbated when the disease, like so many diseases, can be caused by a number of different factors, some of which may be related to work and others not. The fourth step involves determining the weight to assign to the various pieces of evidence. This is where the adjudicator has to be bound by legal standards that may be quite different from scientific standards. Scientists can discount data if they consider it to be 'poor' data, inconclusive or resulting from badly designed studies. Data can also be considered poor if the studies were inadequately controlled or too small to yield statistically significant results. However, in a legal test, all evidence needs to be considered and weighed. The reasons the scientists use to disregard studies should be used to determine the weight assigned to the information/data that the study yielded.

Also, in cases of uncertainty, an adjudicator has to consider alternative hypotheses. For example, a series of weak, small studies or studies that indicate there could be an association to work factors, could, in the absence of other evidence, be considered sufficient evidence. However, in the presence of an alternative hypothesis, the evidence may not be considered sufficient.

Concept 8. The structure of the Workers' Compensation Board must recognize, support and reinforce the role of adjudicators in decision making.

6. Legal issues

Section 73(1) (previously s80(1)) of the Act provides that

> Any decision of the Board shall be upon the real merits and justice of the case, and it is not bound to follow strict legal precedent but shall give full opportunity for a hearing.

Although a similar provision in section 92 (previously s86m) applies to the Workers' Compensation Appeals Tribunal (WCAT), WCAT has demonstrated that it is attempting to be consistent in its decision making and willing to consider relevant case law. The case law in this area is limited, mostly, to tort law (see below).

In keeping with its statutory mandate, the Board has developed policy on a wide variety of topics. The policies, directions and guidelines with respect to the interpretation of the

Act are essential as a means of dealing quickly and equitably with the tremendous number of claims that are filed. However, some policies have been challenged by WCAT decisions when the panel has considered that it 'derogates from the intent of the legislation' (WCAT Decision #131) or is perceived to be unfair.

7. Standard of Proof

There is no statement in the Act or Board policy regarding the general standard of proof.

> The balance of probabilities standard of proof is applicable to findings of fact in civil court cases and is the standard which both the WCB and the Appeals Tribunal apply.[10]

There are difficulties with the concept of standard of proof in workers' compensation claims. The WCB is an investigative as well as an adjudicative agency, and, according to Dee et al,[11] 'an adjudicator, who is not going to make a decision unless totally convinced of one view or the other by the evidence which has been gathered, will be applying too high a standard of proof.'

> The WCAT has been very consistent in making findings on a balance of probabilities and this approach may influence the Board in its day-to-day operations (for example, see WCAT Decisions No.: 38, supra, note 6; 127, supra, note 7; 161 (April 1986); 115 (May, 1986); 55 (March, 1986).

Section 4(4) of the Act reads

> In determining any claim under this Act, the decision shall be made in accordance with the real merits and justice of the case and where it is not practicable to determine an issue because the evidence for and against the issue is approximately equal in weight, the issue shall be resolved in favour of the claimant.

WCAT Decision No. 127 has also made it clear that, in at least one panel's opinion, the burden of proof is according to a subjective standard, i.e. the decision is based on the effect on the individual worker rather than on how an 'ordinary worker' would be expected to be affected.

In cases of injury, if there are multiple causes of the disability it must be established that

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[10] WCAT Decision # 2 (January, 1986)

[11] Dee, G. N. McCombie and G. Newhouse. Workers' Compensation in Ontario. Butterworths, 1987.

the 'personal injury by accident' contributed in a significant or material way to the disability.[12]

8. Case Law on Causation and Disease

Over the past few years there has been a lot of discussion about how cause is analysed and decided upon in the workers' compensation system. Assistance in interpreting the language of the legislation has led to examination of court decisions that deal with similar issues. The task force has reviewed some of these decisions and, in particular, a memorandum of law prepared for discussion at WCAT entitled 'Causation and Disease - A review of court cases and tribunal decisions'.

The document deals with a number of issues including: causation: general test of material contribution; material contribution and the Snell test; material contribution and statistical evidence; epidemiological evidence; and how these issues have been dealt with in various court cases and tribunal hearings.

Several excerpts from the document that the task force found particularly pertinent to its considerations are reproduced below:

- A material contribution is something beyond a de minimus contribution. (but does not have to be 'more probable than not' the cause).

- Cases in which the evidence is scarce or seemingly inconclusive present the greatest difficulty. It is perhaps worthwhile to repeat that a judge will be influenced by expert scientific opinions which are expressed in terms of statistical probabilities or test samplings, but he or she is not bound by such evidence. Scientific findings are not identical to legal findings. Recently in Snell v. Farrell, [1990] 2 S.C.R. 311, this Court made clear that "[c]ausation need not be determined by scientific precision" and that [i]t is not .. essential that the medical experts provide a firm opinion supporting the plaintiff's theory of causation" (p 330). Both this Court and the Quebec Court of Appeal have frequently stated that proof as to the causal link must be established on the balance of probabilities taking into account all the evidence which is before it, factual, statistical and that which the judge is entitled to presume. (emphasis added)

The approach taken by the WCAT panel in Decision 257/89

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[12] See Oates v Earl Fitswilliam's Colleries Co., (1939) 2 All E.R. 490, at 502 (C.A.); Workers' Comp. App. Bd. v. Penny (1980), 38 N.S.R. (2d) 623,69 A.P.R. 623, 112 D.L.R. (3d) 95 (C.A.); WCAT Decisions No. 17 (February, 1986), No. 32 (June, 1986), No. 36 (June, 1986).

is consistent with that in Rothwell,[13]

- "Epidemiological studies may demonstrate a statistical association between a disease and an exposure or risk factor." Thus, they do not prove causation in a particular case but can assist in judging whether a disability is likely work-related. The weight given to a study will depend on the extent to which causation can be inferred from the statistical associations in the study, and the extent to which the individual's circumstances are comparable to the population studied.

Another useful review of probabilistic causation in tort law was prepared by John Fleming in December 1989.[14] The conclusion of this review states,

> A principal question is whether legal routines can adapt themselves to changing scientific epistemology based on probabilistic evidence. As is to be expected, the law has moved cautiously, accepting neither the extreme of categorically refusing to budge from its traditional roots nor of abandoning the conventional insistence on particularistic evidence in all circumstances. But as yet we are only on the threshold of this new territory, still in the process of probing rather than expecting definitive answers.

Following a review of the legislation and case law, the task force has accepted that under the current legislation the basic test for causation of an occupational disease is proof that work made a significant contribution to the onset of the disease. This proof is on the balance of probabilities. **It must, however, be emphasized that the understanding of significant contribution in any given case does depend substantially on the nature of the illness and the mechanism by which the workplace can cause it.** Five examples of different 'types of cause' were identified above (Causal relationships to work).

The task force is aware that many advocate quite different positions. There are those who advocate that evidence of <u>any</u> causal relationship, regardless of degree, should be sufficient and that the WCB should not inquire into the sufficiency of the relationship. The other extreme is that the evidence must show that work was the predominant cause of the illness.

It would seem that neither of these two views can be justified under the present workers' compensation legislation, nor are they consistent with the law. This is indicated most

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[13] <u>Rothwell</u> v. <u>Raes</u>, 66 O.R. (2d) 449; Ont. C.A. (unreported, Dec 14, 1990); affirmed (SCC) May 23, 1991. This is one of the few Canadian cases to discuss epidemiology.

[14] Fleming, J.G. Probabilistic Causation in Tort Law. The Canadian Bar Review, v.68, n.4, p.661-681, 1989.

recently in the decision of the Supreme Court of Canada in Laferriere v. Lawson.[15] The law does require that there be proof that the alleged cause be sufficient or adequate to cause the damage; hence a significant contribution is required. However, as to whether or not the alleged cause was the cause in the specific individual case, the law requires proof on the balance of probabilities. It is sufficient that the likelihood of causation be real and credible by a combination of factual and statistical evidence. In a compensation case, where the evidence for and against is equal, the benefit of the doubt is given to the worker.

These principles are not unique to compensation law. They represent the basic underlying principles of entitlement in most forms of civil liability in Canada.

Concept 9. Causation is established when it is shown, on the balance of probabilities, that work made a significant contribution to the illness. This concept recognizes that there are different mechanisms by which illness is caused, that the workplace can play different roles in the onset of illness, and requires, as a threshold, that the role or contribution of work must be material/significant to the disease process in some way.

[15] Laferriere v. Lawson, (SCC) (unreported, March 21, 1991). This case contains discussion of the use of statistics.

III ANALYSIS

A. THE LEGISLATIVE BASIS AND WHAT IS INCLUDED AS INDUSTRIAL DISEASE

In this section there is a list of the sections of the Workers' Compensation Act of Ontario that are pertinent to occupational/ industrial diseases. This is followed by a brief description of the history of the development of the provisions. The analysis of the legislation is divided into several subsections according to questions asked and issues raised by the task force. These include: the purpose of the Act; provisions for industrial disease, which include sections on definition of 'industrial disease' and schedules; the need for a distinction between injuries and diseases; and, the application of general provisions to occupational diseases.

Most subsections contain a brief description of the 'present situation', followed by a list of concerns raised by the task force or expressed by affected parties. Following the concerns is a description of the task force approach - the analysis, and what is needed to address the issue. The recommendations usually follow each subsection. However, as this section is still identifying the issues and is partly background for the analysis of other components of the system, many of the recommendations are presented later.

The Present Situation

The sections of the Act pertinent to adjudication of occupational/industrial disease include:

s1 "industrial disease" includes,

(a) a disease resulting from exposure to a substance relating to a particular process, a trade or occupation in an industry,

(b) a disease peculiar to or characteristic of a particular industrial process, trade or occupation,

(c) a medical condition that in the opinion of the Board requires a worker to be removed either temporarily or permanently from exposure to a substance because the condition may be a precursor to an industrial disease, or

(d) any of the diseases mentioned in Schedule 3 or 4;

This definition determines which diseases are covered by the Act.
Section 134 identifies the manner in which industrial diseases are to be dealt with (indicating the differences and similarities to the system for injuries by accident).

s134

(1) Where a worker suffers from an industrial disease and is thereby impaired or his or her death is caused by an industrial disease and the disease is due to the nature of any employment in which the worker was engaged, whether under one or more employments, the worker is or his or her dependants are entitled to compensation as if the disease was a personal injury by accident and the impairment was the happening of the accident, subject to the modifications hereinafter mentioned or contained in the regulations, unless at the time of entering into the employment the worker has wilfully and falsely represented in writing as not having previously suffered from the disease.

The modifications are specified in the subsequent subsections. These are briefly reviewed below.

s134

(2) by whom compensation payable - last employer
(3) & (4) how the last employer may bring in former employers
(5) where disease results from a gradual process, other employers may be required to make contributions
(6) fixing of compensation, which differs if the worker is no longer engaged in the occupation the Board may decide an amount it considers fair and equitable
(7) the notice given to last employer even if the worker has left the employment
(8) charging compensation to particular classes

This group of subsections deals with the means of charging employers with the cost of compensation for industrial diseases. They differ slightly from those for injuries to take into account latency of some diseases and the slowly progressive nature of others. Therefore, the provisions make allowances for situations where the worker may no longer be in the same employment that caused the disease and where there may have been more than one employer involved. Analysis of these provisions is included in Section E: 'Funding'.

(9) the presumption for Schedule 3

If the worker at or before the date of the disablement was employed in any process mentioned in the second column of Schedule 3 and the disease contracted is the disease in the first column of the Schedule set out opposite to the description of the process, the disease shall be deemed to have been due to the nature of that employment unless the contrary is proved.

(10) the presumption for Schedule 4, which is irrebuttable[16]

These two subsections deal with the nature and purpose of the schedules. This is unique to the section on industrial diseases because it allows group data to be used. It provides adjudicators with the authority to determine entitlement for workers that have a specified disease and who work in a specified type or place of work.

(11) Remuneration of medical officers for examinations required under the Occupational Health and Safety Act for mining from the rates for payment of silicosis claims

(12) conditions upon which compensation granted for silicosis

This identifies specific criteria for one disease in the Act and is therefore an anomaly. There is no longer a silicosis fund.

(13) agreements for cost sharing with other Canadian jurisdictions

(14) agreements for sharing costs of industrial noise claims

These two subsections appear to be very similar. The need for the distinction is unclear other than the (presumed) greater ability to determine the proportion of exposure to noise that occurred in each jurisdiction.

(15) coverage for diseases resulting from a compensable injury

As this subsection is dealing with diseases that are not industrial diseases, the issue is whether the provisions for cost allocation and sharing apply if the disease can be attributed to an injury.

(16) extension of section to pneumoconiosis and stone worker's or grinder's phthisis

It is unclear why these specific diseases have a special provision in the Act, especially as their importance is mostly historical.

(17) additional industrial disease

The Board, subject to the approval of the Lieutenant Governor in Council, may declare any disease to be an industrial disease and may amend Schedule 3 or 4 accordingly.

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[16] The use of 'disablement' rather than 'impairment' in these two subsection is discussed on page 50.

This provision is to allow the schedules to be amended by regulation, rather than by going through the legislative process.

In addition to these special provisions for industrial disease, there is the option of including a disease as a disablement under the definition of 'accident' in section 1(1) of the Act

> "accident" includes,
> (a) a wilful and intentional act, not being the act of the worker,
> (b) a chance event occasioned by a physical or natural cause, and
> (c) disablement arising out of and in the course of employment.

In these cases the provisions outlined above for industrial diseases would not apply. The adjudication and other provisions of the Act dealing with injuries would apply. Like other conditions that are adjudicated as disablements, the presumption in s4(3) would not apply:

> Where the accident arose out of the employment, unless the contrary is shown, it shall be presumed that it occurred in the course of the employment and, where the accident occurred in the course of the employment unless the contrary is shown, it shall be presumed that it arose out of the employment.

This means that to be compensable, the disablement must arise out of and in the course of employment.

In order to understand the provisions in section 134, it is necessary to briefly review the origin of the various provisions.

History of the Development of the Provisions for Industrial Disease Compensation

At the time the Act was introduced, industrial diseases were recognized as presenting different problems to adjudication. It was clear that Meredith, in his Final Report,[17] recognized the need for compensation of industrial diseases.

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[17] Meredith, Sir W.R. Final Report on Laws Relating to the Liability of Employers - To make compensation to their employees for injuries received in the course of the employment which are in force in other countries. Printed by order of The Legislative Assembly of Ontario (by L.K. Cameron), Toronto, 1913.

> It would, in my opinion, be a blot on the act if a workman who suffers from an industrial disease contracted in the course of his employment is not to be entitled to compensation. The risk of contracting disease is inherent in the occupation he follows and he is practically powerless to guard against it. A workman may to some extent guard against accidents, and it would seem not only illogical but unreasonable to compensate him in the one case and to deny him the right to compensation in the other.

For these reasons 'industrial disease' was defined in the legislation, and there was provision for and the attachment of a schedule. The definition of industrial disease in the original Act (1914) was,

> Industrial disease shall mean any of the diseases mentioned in schedule 3, and any other disease which by regulations is declared to be an industrial disease.

Therefore, until it changed in 1947, the only means of recognizing and compensating for an industrial disease was if the disease appeared on the schedule. The list was expanded by the legislature from the original six to the present 20 or so, and provisions were added for silicosis and the other pneumoconioses. These latter provisions also specified a time limit between the exposure and submitting a claim, and a minimum exposure time (within Ontario). These provisions were modified several times before 1945.

In 1947 the definition was expanded to include 'any other disease peculiar to or characteristic of a particular industrial process, trade or occupation'. As the Royal Commission on Asbestos (RCA) pointed out,

> This amendment greatly liberalized industrial disease compensation policy in Ontario. It also vested the Board with the broad discretion it possesses to the present day. Schedule 3, meantime, remained available as a means of structuring the Board's discretion and indeed was made more readily available than heretofore by an amendment, which transferred the approval of future changes in Schedule 3 from the Legislature to the Lieutenant Governor in Council. Henceforth the Board need only secure an order-in-council to change Schedule 3.

Even though there were numerous additions and amendments to Schedule 3 prior to 1947, there have been only three or four minor modifications to existing entries since that time. It has been speculated that it was the greater flexibility granted to the Board, through the expanded definition, that diverted the attention from the schedule and provisions of the Act to policies, guidelines and criteria. However, there was little guidance on the interpretation of 'peculiar to or characteristic of', and a large proportion of claims were adjudicated on a case-by-case basis.

In 1963 the definition of accident was expanded to include 'disablement arising out of and in the course of employment'. This allowed the inclusion of a number of conditions that previously could not have been included in the definition of injury by accident because of their incipient onset. Some such conditions like infected blisters, tenosynovitis and bursitis had been covered by adding them to the schedule. Even though they could now be included as disablements under the definition of accident, amendments have not been made to the schedule, and these conditions remain classified as 'industrial diseases'.

In a Workers' Compensation Appeals Tribunal (WCAT) decision[18] the disablement clause was interpreted to also include diseases.

1. Purpose of the Act

The mandate of the task force was to examine the principles underlying the WCB's approach to the adjudication of occupational and industrial disease claims. The principles underlying the adjudication of industrial disease have to be consistent with the governing legislation. Usually, principles guide interpretation to ensure that the intent is accomplished. Therefore, one of the first tasks was to examine the Act.

Concerns

Most of the problems in adjudicating industrial disease claims are attributable to the difficulty in determining a relationship to work. Therefore, most of the concerns with the interpretation of the Act arise around the lack of guidance in cases where a number of factors can cause the disease, some of which are work related and others not. Examples of the questions asked about the legislation are listed below.

- Is it intended to provide compensation for victims of a disease if their employment can be shown to have increased the risk of contracting the disease? Even in the presence of other, perhaps strong, risk factors that are not related to employment?
- What level of certainty is required? What level of contribution by work is required to entitle a worker to compensation?
- Is the issue the worker's disability and need for financial support?

There has been a question about the strict interpretation of 'industrial disease' and 'due to the nature of any employment in which he or she was engaged'. It appears as though some believe that it would (should) exclude a disease that is an industrial disease (characteristic of an occupation) in a worker that is not in that occupation, even though the worker may be exposed to the same causative agent. This would mean that a typist

[18] WCAT Decision No. 850 (1988)

at a welding company who is exposed to welding fumes would not be entitled to benefits because he or she is not a welder.

A concern often expressed by employers is that, especially in cases of multifactorial diseases, the Act is being interpreted beyond the original intent. An article entitled 'Workers' Compensation and Occupational Disease: A Return to Original Intent'[19] exemplifies this concern. The article commences

> During the last twenty years, the workers' compensation system has expanded dramatically. This expansion was precipitated by increased public awareness about occupational diseases and a concomitant demand for compensation for diseases once thought not to be work-related.

The article examines the various justifications for workers' compensation in the United States, including legal, economic and social reasons.

Therefore, a question asked by the task force was, 'What is the intent of the Act?'

Analysis

In approaching the issue of the intent of the legislation the task force heeded the advice in Maxwell on The Interpretation of Statutes (12th Edition): '... the intention of Parliament must be deduced from the language used.'

The wording and the history of the development of the Act in Ontario indicate that the system is a no-fault insurance scheme (collective liability) to provide workers or their dependents with fair and adequate compensation for injuries or illnesses that result from the worker's employment. It has been considered a 'trade off' where workers lost the right to sue employers. Meredith recommended that workers be precluded from suing their employers in return for guaranteed compensation funded by all employers.

Nevertheless, concern has been expressed that the precise intent of the Act is not very clear. Questions of its intent are listed below.

1) Is it strict liability for employers to pay for work-related injuries and illnesses (focus on fault - a compensation scheme)?
2) Is it an insurance scheme for employers to cover the cost of work-related injuries and illnesses (focus on cause - a scheme of income replacement)?
3) Is it income support for workers that are disabled and unable to work (focus on disability - a scheme of income support)?

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[19] Peirce, E.R. and T. Morehead Dworkin. Workers' Compensation and Occupational Disease: A return to original intent. Oregon Law Review v. 67, p.649-689, 1988.

The difference between these alternatives may be subtle and, in many cases, of little consequence. However, such differences can alter the approach taken to adjudication, especially for multifactorial diseases where work is only one of the factors and where the employer has a limited ability to control the factors.

The WCB gives some 'mixed messages' about the intent. The Act focuses on cause and disability although some of the benefits cannot be considered as totally income replacement; for example, partial disability does not necessarily result in partial income.

Although the scheme is 'no fault', experience rating programs reward employers with good records and penalize those with poor records. Added to these, there are provisions in the legislation for penalty assessments (section 103(4)). Generally, these have been considered incentives to employers to improve safety and health conditions at the workplace rather than to attribute blame or fault. The applicability of experience rating and penalty assessments to industrial disease will be discussed later in the section on funding. There are two exceptions to 'no fault' for workers: 1) if the injury (not resulting in serious disability or death) is attributable 'solely to the serious and wilful misconduct' of the worker (s4(7), and 2) for industrial disease, if the worker misrepresents him/herself as not having previously suffered from the disease (s134(1). These two provisions, s4(7) and s134(1), can be regarded as necessary controls to preserve integrity and avoid abuse of the system. However, the latter poses an interesting question for chronic conditions that may have been caused by previous employment and are aggravated by work factors.

Some observers consider that the intent of the legislation is quite clear, as are the principles guiding adjudication and provision of benefits. This has certainly been considered the case for injuries and sudden onset conditions, which were considered of primary importance when the Act was developed, and still form a large proportion of the claims. Similarly, the intent of the legislation is quite clear for scheduled diseases. The addition of provisions for chronic conditions that take time to develop has clarified the intent for cases of 'disablement'. Guidelines have been developed for many conditions, and 'case law' has accumulated (see section on Case Law in the previous section).

The greatest concern about the interpretation of the Act involves multifactorial diseases and situations where work contributes to the development of the disease. The approach could be different depending on the intent of the legislation. The examples below are offered as a simplistic illustration of the differences.
(1) If the intent of the legislation were to attribute fault, work would need to be the overriding or 'predominant' cause, or it could even be interpreted as sole cause.
(2) If it were income replacement or supplement for workers with injuries or illnesses caused by work, entitlement would be based on work contributing to the cause to a

'significant' degree or, perhaps, there would be prorating of benefits such that employers only pay for the proportion of the illness that could be attributed to work factors.
(3) If it were income support for disabled workers, then 'any work' contribution should be sufficient to entitle a worker to benefits.

It is interesting to note the approach of other jurisdictions faced with these problems. For example, in Manitoba the legislation has been amended to specify the need for dominant cause and has, also by amendment, excluded certain diseases of 'ordinary life'. New Brunswick has proposed amendments to require a preponderance of evidence. According to the interpretation of the California legislation by the Workers' Compensation Appeal Board, any contribution from work, no matter how small, is considered sufficient to entitle the worker to benefits. But New Zealand, which has a comprehensive disability scheme for injuries, but not diseases, amended its legislation to specifically exclude certain conditions (non physical stress, personal injury due wholly or substantially to ageing process, if the property or characteristic is found to any material extent in the non-employment activities or environment of that person.

It appears to the task force that the legislation in Ontario is clear in that any injury or illness that is work related is compensable. The test of 'significant contributing factor' has generally been applied to causation issues in WCAT decisions. Earlier court cases involving workers' compensation have applied a test of 'material contribution', which appears to be substantially the same.[20] The legislation clearly states that in cases where the evidence for and against is approximately equal, the benefit of the doubt is to be given to the worker.

Some comments from employers suggested that entitlement for diseases should be dependent on demonstration that work was the predominant or dominant cause. The task force considered the issue and questioned what it would mean in practice. The points noted in this consideration are listed below.

- It is a deviation from the legislative base in Ontario and would require a legislative amendment changing the intent of the Act
- If, as is most often the case, the cause(s) for a multifactorial disease is/are unknown, the determination is based on estimates of risk. A high risk means that there is a high probability that the worker's disease is caused by the agent, not that the agent was the dominant cause. In other words, high risk does not preclude another risk factor being a major contributor to the cause.
- Such a procedure does not take into account the different mechanisms of action of causal factors.
- If diseases that could be work related are excluded from the legislation, injured workers would have the right to sue employers for those disabilities. This is the case in New Zealand with the recent amendments to its legislation.

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[20] WCAT Memorandum: Causation and Disease - A Review of Court Cases and Tribunal Decisions. Prepared for discussion in April 1992. This document cites the relevant cases for reaching this conclusion.

- What justification could there be for another test? The common law that has developed around fault-based tort cases uses a test of material contribution. Should the test for entitlement for compensation in a no-fault system be more restrictive?

As will be discussed later, the task force emphasizes that if the government is not satisfied with the interpretation that 'entitlement depends on the determination that, on the balance of probabilities, work made a significant contribution to the development of the injury or illness', it will have to amend the Act and specify another intent. Policy makers and adjudicators do not have the discretion to interpret the Act in any other way. They are bound by the legislation.

What is needed

The purpose of the Act needs to be clearly stated and communicated. When the purpose and intent are understood, the confusion and dispute over interpretation will be reduced. It will then be understood that the legislation is the reference point for the development of meaningful and consistent principles that should also be clearly specified by the Board of Directors. These principles then allow for the development of consistent policies. The purpose of guiding principles and policies is to aid in implementing the requirements of the legislation. The nature of the guiding principles and policies will be discussed later in the document.

Summary and Recommendations for the Purpose of the Legislation

Key issues

- following examination of the wording and the common law interpretations, the intent of the Act is clear: a no fault insurance scheme funded by employers to provide compensation for injuries and illnesses when work or work factors made a significant contribution to the development of the injury or illness
- this appears to be the same test that is presently used but not clearly specified.

As it appears that there is a great deal of confusion about the purpose and intent of the Act, to make it clear to all parties what is covered, the task force recommends

Recommendations

#1 that the Minister of Labour ensure that the purpose and intent of the legislation are clear, and, to achieve this, serious consideration should be given to including a statement of purpose and intent in the legislation either as a preamble or as an initial section on intent.

#2 that the Board of Directors of the WCB ensure that the purpose and intent of the legislation are clearly communicated and that this intent is used as the basis for the guiding principles developed and used by the WCB in administering the Act.

2. Provisions for Industrial Disease

After considering the purpose of the Act, the task force asked included, What is an 'industrial disease'? Why are there separate provisions for industrial diseases? What are the differences? Are they necessary? and, Are they adequate?

As a means of addressing these questions the task force looked at the definition of 'industrial disease', considered the differences between injuries and diseases discussed in the previous section, the origin of the provisions in the Act (see previous subsection), and then reviewed the present practice of adjudication and the problems or concerns expressed. The next step was to determine whether the practices currently used in adjudication were consistent with the provisions of section 134, and whether the decisions would have been different had claims been adjudicated as 'disablements' under the definition of 'accident'.

a) Definition of industrial disease

Industrial disease is defined in s1(1) of the Act and includes not only diseases listed in the schedules and those 'peculiar to and characteristic of a particular industrial process, trade or occupation', but also diseases 'resulting from exposure to a substance relating to a particular process, a trade or occupation in an industry' and what are commonly termed 'precursor conditions', which require a worker to be removed from exposure to a substance.

Concerns

The term 'industrial' is considered by many to be too narrow and limited to industries. It reflects the historical origin where diseases were associated with an industry before cause(s) were identified. Many respondents to the task force's questionnaire favoured the use of 'occupational' as it is more appropriate to cover diseases due to the nature of any employment.

Linking diseases with specific industries also overlooks the fact that conditions and processes vary within industries. Therefore, if a disease is associated with high exposures to a particular chemical, different companies may have substituted the chemical, used different processes or reduced exposures by other means. Therefore, the automatic association with an industry can be misleading.

A few respondents pointed out that the name is irrelevant. It is the definition that determines what is included and, therefore, what is compensable. Others claimed that there is no such thing as an industrial disease: most diseases may or may not be due to the nature of employment. Take, for example, lung cancer - Is it an 'industrial disease'? This leads to a concern expressed by some employers that 'diseases of everyday life' or diseases with more than one cause, some of which are known to be associated with lifestyle or environmental factors, should not be included as industrial diseases.

Owing to difficulties attributing cause to such diseases, and the belief that the other, perhaps better known, causes are within the worker's span of control (not the employer's), employers do not believe that they should be included as compensable under the Act. On the other hand, workers believe that if their employment increased their risk of developing a specific disease, they should receive compensation if they develop that disease.

A concern expressed by Professor Ison to the task force, and elsewhere,[21] is that the whole system is based on a false premise, i.e. the assumption that it is possible to determine the etiology of disease, not just in general, but case by case.

Concern was also expressed about specific details of the definition:

- What about a precursor to a disease? Can it really be considered an 'industrial disease'?
- What about over-exposure to an agent or substance (e.g. radiation) where there is no 'medical condition', just a dosimeter reading that indicates that a worker should be removed from further exposure?
- When a disease that is caused by agent X used in process Y develops in an office worker exposed to X (due to proximity to process Y) is it compensable? In other words, would the disease be 'due to the nature of any employment in which he or she was engaged'?

Some observers of the system and respondents to the questionnaire questioned the distinction between injuries and diseases and the need for it. These questions are pertinent in light of some of the WCAT decisions, which allow a disease that could not be considered an 'industrial disease' by the tribunal's interpretation to be adjudicated as though it were an injury by accident or a disablement. Similarly, how can the distinction be meaningful if some conditions considered to be 'disablements', like bursitis and tenosynovitis, are included in the schedule of industrial diseases?

Some concerns were expressed to the task force that the level of 'proof' and/or degree of contribution required for entitlement to benefits is different for industrial diseases compared with injuries.

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[21] Ison, T.G. Compensation for Industrial Disease Under the Workers' Compensation Act of Ontario. Prepared for and Issued for discussion purposes by the Industrial Disease Standards Panel, September 1989.

Analysis

The first question in an analysis of a definition has to be why is the term defined. Presumably, it is to cover or include something that would not otherwise be covered. Does it cover what is intended? Does the definition make a distinction and, if so, why?

Considering the purpose of the Act and the interpretations discussed in the previous sections, the task force believes that any injury or illness to which work made a significant contribution is eligible for compensation under the Act. Therefore, the definition of 'industrial disease' is only important to allow for differences in the types of benefits, means of funding or types of presumptions that can be applied.

The presumptions are important for aiding in the determination of a causal relationship to work. As noted above, many of the concerns and difficulties in determining a causal relationship, although more common for diseases, are the same for injuries, disablements and diseases. There is a wide range of diseases and injuries, and many of the characteristics attributed to diseases are also common to some injuries; for example, long latency, chronic onset and slowly progressive nature. Figure 4 is presented to illustrate the range of diseases and injuries.

The difficulties created by using definitions in an exclusionary manner is also illustrated by the actions of the WCB. For example, when conditions not fitting the classic definition of injury by accident or 'industrial disease' were recognized as being related to work and therefore requiring compensation, various provisions were added to the Act and definitions were expanded. However, rather than acknowledge the overlap these changes led to more distinctions. The task force considers that this has detracted from the recognition of the continuum and explains why some diseases are being forced into definitions of injury and some injuries may be better dealt with as 'diseases'. Confusion and misunderstanding have resulted. Such distinctions and confusion could allow certain conditions to 'slip through the cracks'. For instance, can diseases that are common in the general population and also known to be caused by factors other than work be classified as 'industrial' diseases?

Returning to basic principles, entitlement depends on the determination that, on the balance of probabilities, work made a significant contribution to the development of an illness, injury, or disability.

Hence, the advantage of the definition of occupational disease is that it provides a mechanism for group data to be used to demonstrate a relationship between a set of work conditions and a disease. This means that an association derived from group data can be 'particularized' and applied to help adjudicators determine work-relatedness in cases that would be difficult on a case-by-case basis. When such associations are identified, guidelines or policies can be developed (see later).

This provision, allowing group data to be used to help make determinations of causal relationships in particular cases, is illustrated in the terms used to describe the nature of association to work that needs to be established before entitlement can be granted. The key phrases in the legislation are 'due to the nature of any employment' for diseases and 'arising out of and in the course of employment' for disablements.

'Due to the nature of any employment' and 'arising out of and in the course of' include situations in which factors not related to work play a role; but work

- contributes to the cause
- exacerbates symptoms
- provokes the onset of symptoms of a pre-existing disease
- triggers a response (e.g. isocyanate sensitization/asthma).

As noted above, all are compensable. However, there are differences. This leads the adjudicator struggling to determine entitlement with a number of questions. Which are occupational diseases? Which can/should be considered 'disablements' and 'arising out of and in the course of employment'? Is this the same as 'due to the nature of any employment'? .

The advantage of the definition of occupational disease is to allow for the use of group data to demonstrate a causal association when the causal agent or mechanism of action is unknown. When the causal agent and/or mechanism of action is known, the process of determining association to work is more like that for 'disablements', i.e. the issue is no longer could work cause the disability. Examples that could be included in this group are precursor conditions, chronic poisonings, and possibly, conditions like chronic obstructive lung disease. Hence the need for another group or a definition of occupational disease to provide a mechanism for dealing with situations where the only data are the demonstration of an association between a type of work or work environment and a disease that is/may be relatively common in the general population. In these cases, it has to be determined from the group data whether the association is sufficient to consider, 1) whether, on the balance of probabilities, that that work environment made a significant contribution to the development of the disease in the work environment; 2) whether the association can be generalized to other work that has the same or similar work environment, 3) whether the association is attributable to a specific factor and that it is a causal relationship.

Some jurisdictions, like Saskatchewan, do not make a distinction between disease and injury, all are adjudicated according to the same criteria - determining disability and an association to employment. Other jurisdictions, such as California and Sweden, make a distinction based on the means of onset. The distinctions are injury and cumulative injury. In these cases, repetitive strain injuries and chronic obstructive lung disease would be dealt with by using the same set of principles and guidelines regardless of whether they are considered injuries or illnesses. Some jurisdictions include diseases in the definition of 'injury by accident'.

It appears that the main reason for the different provisions for industrial diseases and injuries is evidentiary - in recognition of the greater difficulty of determining a relationship to work. Presumably, this is why certain diseases can be recognized by group data as having a relationship to a particular process, trade or occupation, and hence can be included in the definition of an 'industrial disease'. When such diseases are adjudicated on a case-by-case basis as an injury or 'disablement', it is difficult to establish 'arising out of and in the course of' for an individual case.

The other difference in the legislation for dealing with industrial diseases is the provisions for schedules accompanied by presumptions. It appears as though these are based on the same premise - the need for a mechanism to deal with the difficulties showing an association between work and a disease in an individual case. This is especially important when the disease has a gradual or delayed onset and/or there are a number of possible causal factors.

It is interesting to note that when the Act was amended and the term 'impairment' was introduced and defined, 'disabled' 'disablement' were replaced in many sections describing the effect on the worker that entitled the worker to compensation. Although replaced in s134(1), disablement remains in ss(9 & 10), which describe the presumption that applies to the schedules. The task force wondered whether this meant that the worker had to lose earning capacity prior to being eligible for the presumption in these two subsections or whether it was to determine a date of onset/diagnosis: when the worker lost earning capacity.

Also raised was the question of whether it should require the demonstration of a disability rather than impairment for a worker with a precursor condition, under the definition of industrial disease, to be eligible for compensation. Workers that have been over-exposed to radiation probably do not have an impairment, but should be removed from work or further potential exposure and therefore, should be eligible for compensation. It could also be questioned whether radiation measured on a dosimetric badge could be considered a 'medical condition'. Perhaps over-exposure to radiation would more clearly fit the definition of injury by accident as a disablement.

These are further examples of why it is important to specify the intent of the Act clearly and have a general inclusive definition.

In summary, it appears that the reasons for separating categories of disabilities for the purposes of adjudication can be considered to be evidentiary.[22] The different categories have different provisions or presumptions and a different requirement for showing the association to work,

- injury by accident with the presumption in s4(3) regarding 'arising out of' or 'in the course of employment'
- disablement where the presumption does not apply
- industrial disease according to the definition and 'due to the nature of any employment',
- scheduled industrial disease with the presumption in s134(9) for Schedule 3 and s134(10) for Schedule 4.

These differences are to facilitate the decision-making process and provide for a fairer distribution of costs.

The task force supports the view that 'industrial' tends to imply restricting the conditions to those linked to particular industries, even though this has not been the practice of the Ontario WCB.

Recommendation

#3 that all reference to 'industrial' disease in the Act, policies and guidelines be changed to 'occupational' disease

The importance of a definition of 'occupational disease' is dependent upon what it means in the context of the Act. Therefore, further analysis and discussion of what is needed to clarify the definition (and what is covered) is integrated into the next subsection, which includes discussion of the rationale for different and distinct provisions for dealing with diseases and injuries.

b) Schedules

Schedules are lists of 'industrial diseases'. Like those in many other jurisdictions, the schedule was based on a list of occupational diseases compiled by the International Labour Organization (ILO). Inclusion on the list has depended on there being 'sufficient' information available, usually from group data, to clearly establish an

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[22] This is compared to the more common means of separating categories of adverse health effects that are:
1) medical, i.e. by diagnosis for the purposes of treatment and rehabilitation. Such a separation would also tend to group conditions into injuries and illnesses by the nature of the condition as discussed earlier, and
2) scientific or by cause. Examples of this categorization are usually for diseases, especially when one cause has one specific manifestation, e.g. silicosis, or a manifestation that may be shared by other causes, lead poisoning.

association between the disease and employment/process, and little opportunity for the disease to be contracted by other means. Initially, only the diseases so listed were recognized as industrial diseases for compensation. The association to work was presumed if a worker that had the disease was working in a process or trade listed. The presumption for Schedule 3 is rebuttable (unless the contrary is proved) whereas that for Schedule 4 is irrebuttable.

Concerns

- Schedule 3 is not up to date and rarely used.
- The diseases listed bear little resemblance to diseases presently found in the workplace.
- Most of the diseases are not consistent with present diagnostic codes (and cannot be traced in the Occupational Disease Information Surveillance System ODISS).
- Many of the diseases are very uncommon, and the processes listed are non-specific.
- In some cases there are no processes listed in Column 2. This could imply that <u>any</u> occurrence of the disease would be occupational. The task force finds it hard to believe that <u>every</u> case of tenosynovitis or bursitis would be considered an industrial disease and therefore compensable.
- It appears as though there are cases where the presumption could <u>not</u> be applied. For diseases listed as 'Poisoning and its sequelae by ....' the diagnosis is dependent on identifying the causative agent.
- In other cases the conditions of work are specified in Column 1 under 'Description of Disease' and Column 2 'Process' is vacant.
- Some of the 'diseases' described are not generally considered diseases, e.g. infected blisters, and others are commonly considered and adjudicated as 'disablement', e.g. bursitis and tenosynovitis.
- The use/usefulness of schedules is very limited if they can include only diseases for which there is only one cause.
- There is no means of specifying 'qualifications' or criteria in schedules. For many multicausal diseases, the association to a substance or work factor or process depends on the intensity and/or duration of exposure. With low or short exposures there may be no evidence of association between the disease and work. Other factors such as the length of time between the relevant work and the development of symptoms are important indicators of the likelihood of the disease being related to the employment. It could have been in recognition of the difficulty of incorporating diseases with such qualifications into schedules that special provisions were included in the legislation for silicosis, pneumoconiosis and stone worker's and grinder's phthisis.
- Because of these limitations, there has been a tendency not to use the schedules, and, therefore, the intent of the presumption has not been achieved.
- The adjudication process for diseases on a schedule with a rebuttable presumption may not be significantly different from case-by-case adjudication. The reasoning

behind this concern is that all the evidence is sought in order to determine whether 'the contrary can be proved'. The implied difference is whether the adjudicator is gathering evidence to grant the claim or to deny it.

A number of jurisdictions do not have schedules; examples in Canada are Sasketchewan and Manitoba. In some jurisdictions, like New Zealand, Sweden and California, the concept and use of schedules have been rejected because such lists are considered limiting. There is the belief that if a disease is not on the schedule, it is unlikely that it will be considered an 'industrial disease' and therefore unlikely to be compensated. This has been the case in Great Britain and was commonly considered to be so in British Columbia. Such an approach is a problem both for workers and examining physicians as they are less likely to submit claims. It also poses problems for adjudicators determining whether the disease is an industrial disease.

Analysis

The task force notes the value of lists of diseases with a presumption for the following reasons.

- They provide a mechanism for allowing group data showing associations between diseases and processes to be used to aid adjudicators make decisions for individual cases.
- They have educational value for employers and workers by indicating which diseases and processes are associated and, therefore, potentially compensable.
- They aid adjudicators and allow for streamlining, 'fast-tracking' and consistency in decisions. In the case of rebuttable presumptions, if there is sufficient evidence to meet the conditions of Columns 1 and 2, no further investigation should be required. There should be no need to identify alternative hypotheses. In case-by-case adjudication evidence for and against needs to be balanced.

However, the task force was also aware of the problems with schedule(s). If they are to be used with an irrebuttable presumption, the level of proof needs to be so high and the possibility for other causes so low, that very few diseases would be on the schedule. This also means that it will take such a long time to get the level of scientific certainty and the agreement of the parties that most of the claims will have already gone through the system. Hopefully, by this time preventive action will have been taken and not many claims should be entering the system. Hence, the need for scheduling would no longer be a priority.

In this context it is interesting to note the origin of Schedule 4. The recommendation for the establishment of a schedule with an irrebuttable presumption came from the Royal Commission on Asbestos. The commission expressed concern over the appropriateness of any challenge to the validity of a compensation claim in situations where the claimant's disease and the employment process are both in line with the specification of

Schedule 3. It was noted that rarely were there concerns expressed by employers about the legitimacy of a claim for asbestos exposure. In these cases the presumption was being used as though it were irrebuttable. The commission went on to say that if a disease qualifies for Schedule 3, then 'The relative certainty, to say nothing of the dignity, of the survivors of an industrial disease claimant can be badly undermined by an employer's attempt to rebut the validity of that claim'. Its recommendation was that the presumption for Schedule 3 should be irrebuttable.

Although Schedule 4 has been a component of the Act since 1985, it was only in 1992 that a serious effort was made to add asbestosis and mesothelioma to it. These two diseases are clearly prime candidates and probably the reason that the schedule was established. The problems experienced by the WCB and the Ministry of Labour in trying to add diseases to Schedule 4 serve as excellent examples of the concerns expressed above. The task force acknowledges that any process usually takes longer the first time through and, often, problems that were not anticipated are revealed. However, the issues raised are important: How can policies be made to be retroactive in their coverage? and, What is the role of cost impact analysis in policy development? Some employers express the belief that policies should not be made retroactive.

Following considerable discussion about the value of Schedule 4 with its irrebuttable presumption, the task force, while endorsing the concept, considers that it should not be necessary. If, as is contemplated, Schedule 4 is only to be used for diseases that have only one cause and that cause is most likely associated with work, there would be no grounds for rebutting the presumption even if it were rebuttable. The amount of data that is required before a disease is likely to be contemplated for such a designation is rare and, in such cases, it is already so widely recognized that the special designation becomes meaningless. We would sincerely hope that adjudicators faced with a claim from an asbestos worker with mesothelioma in 1992 would not use a different approach to decision making depending on whether mesothelioma were Schedule 4 or Schedule 3.

In summary, the limitations of Schedule 4 include,

- the data become available 'after the fact'. It is the manifestation of the disease that provides the data, which should have triggered preventive measures,
- it requires regulation and cabinet approval, which takes a long period of time,
- it cannot be made retroactive. Hence, most of the workers with the disease will not benefit from the provision.

What is needed

Recognizing the practical limitations, the task force still endorses the use of schedules with a rebuttable presumption as a means of identifying diseases that have been shown to be related to various processes, agents or conditions of employment. However, in order to make it a useful system and more widely applicable, there should be guidelines to indicate conditions when the disease is unlikely to be associated with the

agent/process/employment. For example, if cancer developed within less than x years of first exposure. These guidelines should not set out specific 'criteria', merely provide the information that indicates the likelihood of such work conditions contributing to the development of the disease. It should be quite clear that failure 'to meet criteria' does not mean that the claim should be denied, only that the presumption does not apply, and that the claim should be adjudicated on its merits on a case-by-case basis.

The task force believes that recognizing that schedules will be used with guidelines to indicate when the presumption can be rebutted, the pressure on 'absolute proof' will not be so great. In other words, diseases could be scheduled, even if work were not the only possible causative factor, as long as there can be some guidance indicating when the presumption is no longer applicable, and when a case should be considered on its own merits.

The focus on specific numbers for determining length and intensity of exposure both for setting guidelines and for determining whether a case meets the guidelines will still present a problem. These problems will be explored more fully later in the document in a discussion of the underlying principles. However, by providing guidance for the use of the presumption and its rebuttal, the controversy over which diseases should be added to the schedules will be reduced. This will allow more diseases to be added and schedules to be used more widely. The schedules will better serve the purpose for which they were designed: expediting claims adjudication and promoting consistency.

To be useful, schedules need to be kept up to date, and the process of adding diseases should not be so onerous as to cause significant time delays or disincentives for their development or use. The issue of how much evidence is enough to schedule a disease and the underlying principles used by the WCB will be discussed later in the report.

The task force reiterates the importance of guidelines accompanying schedules. Such guidelines, as well as indicating conditions when the diseases are less likely to be associated with work, should include specific information on the diseases, and, in cases where it is appropriate, there should be a matrix for guiding adjudicators in the type of information that is needed to rebut the presumption. An important factor to be considered in such matrices is the mode of action of the disease. This will then determine the importance of other factors. For example, latency period will be an important consideration for cancer but not for sensitivities. The timing of the appearance of symptoms with respect to work will be important for sensitivities, etc. Attempts to develop decision trees should be treated with caution as, depending on the circumstances of individual cases, some conditions/information will have a greater relevance in some cases than in others. The relevance of the information will determine how early it should be used in the decision process. Certain decision points could be used to include or exclude cases without adequate consideration of other information. That is why, in most cases, a matrix of information to be considered will be more useful.

Summary and Recommendations for Schedules

This subsection includes a discussion of the advantages and disadvantages of schedules as well as the problems with the present schedules.

#4 that Schedule 3 be reviewed and updated and that the body responsible for policy development[23] be responsible for recommending amendments, as needed, to keep it up to date.

#5 that all diseases for which the data are of sufficient quality[24] to allow for a presumption of work relatedness under specified conditions be added to the schedule.

#6 that guidelines be developed for diseases on the schedule, indicating the information available on the strength, conditions and limitations of the association to work, to provide guidance for situations when the presumption could be rebutted.

#7 that the provision for Schedule 4 with an irrebuttable presumption be repealed.

Although recognizing that if Schedule 3 is used correctly (i.e. when the association is so strong and indicated in the accompanying guidelines, the presumption will be irrebutable de facto), there should not be need to have a separate schedule with an irrebuttable presumption, one task force member expressed concern about removing the provision from the legislation.

3. The Need for a Distinction Between Injuries and Diseases

Following the analysis of the differences between injuries and diseases and the differences in the provisions provided in the Act, the task force made several observations.

- Although there are clear differences between classic injuries and classic diseases, defined characteristics typical of injuries apply to some diseases and vice versa. Injuries and diseases both exist on the same continuum.
- It was in recognition of the fact that there are other medical conditions that may/may not be classified as injuries or as diseases, that a third category of compensable conditions was recognized by the WCB in 1963: disablement under

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[23] The body responsible for policy development will be defined in the section on policy development

[24] The factors to be considered in deciding whether the information is sufficient and of sufficient quality for inclusion to the schedule are discussed in the section on underlying principles.

the definition of accident. Disablements represent a middle area of the continuum being generally medical conditions that have a chronic onset and result from chronic or continuous exposure to a particular process.

- The continuum can also be viewed as representing the increasing difficulty of determining cause and the relationship to work in any one individual.
- There are advantages to having different provisions. Such provisions can provide a mechanism for the easier recognition of medical conditions/disabilities at the far end of the continuum. The mechanisms include the use of group data to indicate that a disease can be related to a particular work or work factor (trade, process or occupation, or exposure to a particular substance or set of work conditions). In cases where the association is clear and well defined, there is the advantage of having schedules with an associated presumption.

Analysis

In deciding whether there is a need for a distinction between injuries and diseases, the task force went back to look at the purpose of the Act and whether making such a distinction helps in its implementation. The purpose of the Act is the provision for compensation for workers with disabilities resulting from injuries or illnesses that are due to the worker's work. Determining entitlement requires determining the relationship between the worker's illness or injury and the worker's employment. As there are many different ways in which work affects a person's health, determining the relationship will be more difficult in some cases than in others. Therefore, different mechanisms are needed to facilitate the process of making this determination. Definitions provide adjudicators with information on which conditions can be caused by which work/work activities. There is need for information on the strength of the association/ likelihood that the adverse health effect is related to certain exposures at work, including duration and intensity where applicable. However **it should be clarified that the purpose of these definitions and different provisions is to aid adjudicators determine whether or not there is a relationship to work.** The definitions should not be exclusionary. All medical conditions resulting from work should be compensable whether they fit a definition or not.

What is needed

Ideally, to clarify the confusion over definitions, which have tended to be used as exclusionary, and to provide a logical framework for the Act, **compensable medical conditions should be defined to include any injury or illness that results from work.** Such a definition should include: the present injuries by accident, disablements, and industrial diseases. It should not be exclusive but illustrative. The differences should not be used as tests for entitlement but to allow for different provisions and presumptions for the different categories, thus aiding adjudicators to determine work relatedness.

The task force recognizes that this would require modifications in the structure of the Act and that there is reluctance to 'meddle' with definitions. Even though the definitions may no longer be explicit in their intent, there is general understanding of their meaning and considerable case law has developed. There is a danger when redrafting definitions that new, unforeseen issues will be raised and new problems created.

The task force considered that to minimize the changes to the Act and maintain the intent, the most logical approach would include,

- having one definition of compensable medical conditions that would have two parts. One would be injuries and sudden onset conditions including the first two subsections of the definition of 'accident'. The second would be conditions with progressive onset and include the present disablements and industrial diseases.
- repealing s134 and adding a simpler section (or subsections to existing sections) to deal with the differences in presumptions for the different component categories, including schedules, and differences in funding systems.

Ideally, these added subsections would be placed together with relevant sections in the main body of the Act rather than separately towards the end of the Act.

The advantages of this approach include,

- the Act would be clearer,
- it would retain, with slight modifications, the present definitions, but under one heading 'compensable medical conditions',
- it would include occupational disease as an integral component of the compensation system, giving it the prominence it deserves,
- it would minimize the need to draw distinctions between injuries and illnesses when, for the purposes of compensation, it is not necessary,
- a number of subsections that are unclear and seldom used would be removed.

Although such modifications would appear to be a major change in the structure of the Act, it appears to the task force that they would make little difference to the way the Act is presently administered for adjudicating industrial disease claims. More meaningful schedules could be developed and fairer cost allocation could be implemented. Section E, later in the report, contains further discussion of funding and cost allocation issues.

Whether or not the government decides to amend the Act, the task force considers it important that,

- there is recognition of the continuum
- it be specified, in the definitions, that diseases can be disablements and disablements can include diseases.

Summary and Recommendations

The task force believes that the Act provides the principles: all types of injuries and illnesses are compensable and workers are entitled to benefits if work makes a significant contribution to the development of the adverse health effect, regardless of whether it is classified as a disease, injury or disablement.

#8 that the Minister of Labour clarify the Act by

- **including one definition of 'medical conditions that are eligible for compensation', meaning any condition that causes a worker to be impaired or disabled if work made a significant contribution to the development of the condition. The definition should be in one section and contain 1) sudden onset conditions, which include the injuries presently covered in the first two subsections of the definition of 'accident', and 2) progressive onset conditions, which include 'disablements' and occupational diseases;**
- **including all the presumptions and requirements for determining causal relationships together in one section of the Act.**

It should also be clarified that the purpose of the categories is to facilitate the determination of a causal relationship to work, and the provisions and presumptions that apply.

Progressive onset conditions include diseases and disablements that can be grouped (not separated) according to differences in process for determining the causal association to work. For instance, cumulative conditions (e.g. disablements, chronic poisonings, precursor conditions, sensitivities) where the causal agent and/or the mechanism of action is known and the causal relationship to work can be demonstrated by determining the worker's exposure. Another group would be diseases for which the causal agent has not been determined and/or the mechanism of action is not known. This will include many cancers where group data indicate an association to a particular type of work or work environment but specific 'cause' cannot be identified. Within this group there will be cases where the evidence of a causal association is sufficiently strong (with or without understanding the causal agent or mechanism of action) that generalizations can be made from the group data and diseases can be scheduled.

Provisions for presumptions and requirements for determining causal relationships that already exist in the Act could then be specified together in one section. For example 'arising out of or in the course of' presumption applies to the first part. For disablements there is the requirement for 'arising out of and in the course of' (no presumption), while for occupational disease there is provision for a schedule with a rebuttable presumption and the requirement, for diseases not on the schedule, to be 'due to the nature of any employment'. The provisions for differences in funding for conditions in the second part of the definition should also be dealt with together in the same part of the Act. The distinction between disablements and occupational disease

should not be so 'exclusionary'. The continuum of conditions (diagrammatical represented in Figure 4) must be recognized. If such an amendment is made, section 134 would be redundant and should be repealed.

#9 that section 134 be reviewed and the subsections that are out of date, those that are redundant and those that are never used be repealed.

The amendments are recommended not to change the Act but to update it, to make it clearer and easier to administer, and to remove sections that are redundant or unnecessary. The task force also considered it important to point out that the changes to the definition will not significantly expand or decrease the number or type of conditions that are eligible for compensation; they will just clarify the scope.

4. Application of General Provisions to Occupational Disease

Other than the differences specified in s134, the other provisions of the Act and general policies also apply to occupational disease.

Concerns

A general concern that was brought to the task force's attention was the difficulty of applying, to occupational diseases, some of the general provisions and policies developed for injuries. Examples that were cited included,

- the application of the Future Economic Loss (FEL) provision. It seems as though the provision does not provide a means of dealing with the slowly progressive nature of some illnesses,
- entitlement for rehabilitation being dependent on demonstration of a disability. This is considered to be counter to the preferred approach of early intervention and initiation of strategies to prevent the condition/disease progressing to the point of it becoming a disablement.

Analysis

There will be further discussion of these concerns later in the document. The issue for this section is the need to recognize occupational disease as an integral component of the compensation system and that although they are adjudicated according to the same provisions of the Act using the same policies, the differences presented by these conditions have to be recognized and accounted for.

What is needed

In order to deal with these types of concerns there needs to be a mechanism for considering the implications to occupational diseases whenever amendments to the legislation are proposed and/or general policies for the WCB are developed. When changes are made or policies developed, guidelines should be formulated for adjudicators and others that have to implement the changes. The guidelines should clarify the application of the policies to occupational diseases or progressive onset conditions.

It is considered essential that the development of such guidelines should include consultation with, or participation by, adjudicators in the CCU-D. The recommendation pertaining to this issue is included in the section on adjudication (Recommendation #43).

B. IDENTIFICATION OF OCCUPATIONAL DISEASE

This section deals with the issue of how an occupational disease is identified, both in general and in an individual case. The legislation provides for compensation of industrial diseases due to the nature of employment. Industrial disease is defined in the Act. There are two aspects of occupational disease recognition/identification 1) where a worker and/or the worker's physician recognizes that a disease could be caused by work and therefore submits a claim, and 2) WCB recognizes that the disease could be due to the nature of work or that it fits the definition of industrial disease.

1. Recognition of Occupational Disease by Workers, Employers and Physicians

The importance of this aspect of disease recognition is often overlooked. Whether or not an occupational disease is recognized by a worker or his/her physician determines which claims enter the system.

Concerns

One of the most common concerns expressed to the task force from management, labour and injured workers groups and even from occupational physicians, was that general practitioners do not have appropriate or adequate training in occupational medicine. There is the concern that, in general, physicians tend not to consider the possibility that an illness may be related to a patient's work. This is part of the reason that doctors are considered to be 'gatekeepers' to the system.

Similarly, employers and workers are often not aware of the hazards of the workplace or the possible consequences. In many instances workers do not mention work to the examining physician.

There is a paucity of information on occupational disease. Information that is available from scientific studies, medical and occupational health information and experiences and practices in other jurisdictions, is poorly integrated into the workers' compensation system. Information collected within the Ontario system is poorly collated and the means of communication within and out from the system is inadequate. Problems with collection and collation of statistics will be considered in the next section.

Analysis

It is likely that the lack of information on occupational disease and hazards of the workplace explains much of the under-reporting of occupational diseases, and is at least part of the reason for the 'gap' between the estimated number of workplace illnesses and disease and the number compensated. Poor communications mean that clusters of

diseases that provide initial indications of links between work and disease are likely to be missed. This means that investigations and identification of causal links will be delayed, as will the very important preventive strategies. The task force recognizes that this issue is peripheral to the WCB and its responsibilities; however, it is an important issue to be addressed. The task force holds the firm belief that the only satisfactory way to deal with occupational disease is prevention.

If there were more information available and a greater awareness of occupational health, there could be a greater emphasis on prevention. Also, if physicians and workers are more aware, there is a greater probability that a claim will be submitted. This will

- lead to early intervention - preventing symptoms from getting worse, better treatment and vocational rehabilitation,
- stimulate investigations and provide more information on hazards,
- allow employers to take preventive actions, which should prevent diseases and reduce compensation costs,
- facilitate the process of identifying occupational diseases and allow better policies to be developed to aid adjudicators deciding entitlement,
- help close the 'gap' between the estimated number of occupational diseases and the number compensated.

What is needed

The task force considers that there should be better education for the general public and, specifically, physicians on issues of occupational health. The emphasis of educational programs should be first and foremost on prevention, then early detection and early intervention to reduce the hazards and the number and severity of the medical conditions caused by work. Only in this way will information on occupational risks and hazards be understood and incorporated into work design. Also, knowledge and understanding should aid early identification of adverse health effects. Although not within its direct control, the WCB should facilitate the process of increasing awareness through contacts with the general educational system and medical and other relevant professional and technical training schools such as nursing, engineering, industrial hygiene, etc. The efforts should be co-ordinated with those of the Minister of Labour through the Workplace Health and Safety Agency.

There should be more and better information given to workers and employers. This could be co-ordinated through the safety associations as well as through awareness raising campaigns by the WCB. There should be better means of collecting and collating statistics so that more information is available. See next section for specific recommendations on this issue.

Recommendations

#10 that the WCB initiate an active communication and education campaign to increase awareness of occupational disease - the effect work can have on development of disease.

#11 that the WCB, through its policy mailings, provide more information on occupational diseases, how they are recognized and how and when claims should be submitted.

#12 that the Minister of Labour and the Board of Directors co-ordinate efforts with other ministries, including Education and Colleges and Universities, to increase the awareness and knowledge base of training physicians, other health care professionals and occupational hygienists on issues of occupational health and disease.

2. Recognition of Occupational Disease by WCB

The WCB can recognize an occupational disease in a number of ways.

- The Act contains a four part definition of 'industrial disease' as well as provision for two schedules.
- Diseases not on the schedules or not fitting the definition have recently been recognized for compensation if they can be considered 'disablement arising out of and in the course of employment' as in injury by accident.
- There are specific policies for a variety of diseases. Such policies identify the circumstances under which a disease is likely to be associated with work and are designed to aid adjudicators.

The identification/recognition of occupational disease, for the purposes of compensation, involves two steps:

a) research - generation and collation of data searching for possible causal relationships and associations with some aspect of work, and

b) recognition by the WCB that a relationship exists. Such recognition depends on interpretation of data and development of policy.

a) Research

Research covers a great number of activities. The focus of this subsection is scientific/medical research, which includes: experimental or observational studies; searches for reports of studies in the literature; interpretation of observational information; and collection, collation and analysis of statistics. Although not directly relevant to this subsection, law research also is important to identification and

recognition of occupational diseases. For example, searches for cases with similar characteristics and analyses of various decisions in the same as well as other national and international jurisdictions.

Present System

Initial indications of a link to work tend to come from experience, such as observations of clusters of diseases or from results of scientific studies or toxicity testing.

The determination of when to investigate a particular disease or set of circumstances comes from a variety of sources including: information from, or initiatives in, other jurisdictions; concerns and questions from adjudicators; pressure from workers or workers' organizations; and concerns through the political process either to politicians or to members of the Board of Directors of the WCB.

The approach in Ontario has been that when questions have been asked or concerns raised, the WCB staff has collected information available from a variety of sources, including the scientific literature and other jurisdictions. Other information may come from sources associated with occupational health.

Until recently, no one organization or agency has had a specific mandate to conduct research towards the identification of occupational disease. However, there is research occurring in a variety of forms in a variety of settings. The WCB itself does not have a specific mandate for research; however, it does collect statistics and investigate clusters.

Individual companies, groups of companies, and trade associations conduct research, often in collaboration with unions. The reasons for initiating research are varied and include pressure from unions, findings from routine health surveillance of workers, concern about the safety of various processes or substances important to that company or group of companies, or to search for means of improving working conditions. Some of the studies within companies have been initiated in response to concerns or suggestions from joint health and safety committees.

Primary or basic research is often conducted at or through academic institutions. Such studies may be funded by companies or through regular government research grants, such as the Medical Research Council and the National Science and Engineering Research Council (NSERC) or through special interest groups or charitable organizations, most notably the Cancer Society through the National Cancer Institute. Other significant or potentially significant sources of research or information are hospitals.

The collection of statistics is a function of many groups, including federal, provincial and municipal government departments, specifically in health and labour, workers compensation systems, and special interest groups. Analyses of such statistics also occur

through departments of biostatistics and epidemiology. Although in many cases the studies and analyses are not specific for occupational diseases, the information generated can be of vital importance to the interpretation and identification of causal relationships for diseases.

Agencies within the Workers' Compensation System involved in/with Research

In 1984 the Workers' Compensation Act was amended to create an Industrial Disease Standards Panel (IDSP). The first two of the four functions listed in s95(8) of the legislation are

(a) to investigate possible industrial diseases;
(b) to make findings as to whether a probable connection exists between a disease and an industrial process, trade or occupation in Ontario;

The first function could be interpreted as a mandate to conduct 'research', at least in the broadest sense; that is, collection and collation of information already available. The second and subsequent functions involve the interpretation of information and decision making to form the basis for policy development. Although the distinction between identification of occupational disease and policy formation is not clear, there is an attempt in this report to deal with the two separately.

The IDSP has sponsored some primary research. The funding has come either directly from its operating budget or as special funds.

In 1990 the Ontario Workers Compensation Institute (OWCI) was established. It does not have a legislated mandate but a contract with the WCB. The three main responsibilities specified are[25], 1) to carry out health care research in order to determine effective and efficient methods of health care delivery for individuals with work related injuries and diseases; 2) to assist in the development of curricula for training health care professionals in new approaches to the medical rehabilitation of injured workers; 3) to develop and operate a comprehensive quality assessment and accreditation program for the community clinics and regional evaluation centres throughout Ontario. Although the focus of the research is medical rehabilitation, the studies planned have wider implications and should be useful for occupational health research and establishing data bases. The potential for relevance to occupational health in general is indicated in the first Newsletter, which stated 'As the primary focus of the Institute, we conduct clinical and population health research into risk factors for work-related injury and illness, as well as the rehabilitation and return to work of injured and ill workers. The research design currently under development is a ground-breaking

[25] After completion of the report, it was brought to the notice of the task force that there had been amendment so that the research mandate was 'to conduct clinical and population health research into factors related to the rehabilitation and return to work of injured workers'.

project because it involves the creation of one of the largest and most diverse work environment and health databases in existence'. The institute has a scientific staff and a research advisory committee that contains scientists of world repute from other jurisdictions.

The Ministry of Labour maintains a small health studies group to conduct research to meet the needs of the ministry. Generally, this involves investigation of specific workplaces or conditions where there is an occupational health concern. There are limited funds available for research, some for in-house studies performed by ministry staff and some for external groups through the grants program. The latter is now administered through the Workplace Health and Safety Agency. As occupational health and safety is the mandate of the Ministry of Labour, there does not appear to be any research into occupational diseases performed by other Ontario government departments. The Ministry of Environment co-ordinates its health studies with the Ministry of Labour.

The Workplace Health and Safety Agency, established in 1990, has, as one of its legislated functions, 'to provide funding for occupational health and safety research'. It has taken over the administration of the research and grants program from the Ministry of Labour (MOL). An inventory of occupational health and safety research was planned by the MOL in 1991, but because of government cutbacks the project was shelved. However, in 1992, the Agency initiated a review to assess effectiveness, needs and options for future strategies for research and related activities in occupational health and safety. The review was to include examination of research resources in occupational health and safety (grants programs of other organizations, researchers, institution, etc.), activities of related organizations, past and current uses and effectiveness of Ontario research grants, and options for strategic direction of the Agency's research/grants program.

Concerns

Many of the groups the task force talked with expressed considerable concern about the duplication and the lack of co-ordination of occupational health and compensation research. Other than the grants program and a small budget in the Ministry of Labour, there have not been any funds devoted to research. There has not been a system for identifying needs or determining priorities. Grants have been awarded on an 'ad hoc' basis with no system of evaluation, oversight or requirements for peer reviews. There has not been a co-ordinated means of dealing with the data or any assurance that the results would be brought to the attention of, or considered by, the relevant policy-forming bodies.

The IDSP has not received approval for a separate research budget, and there have been concerns about the mandate of the OWCI. The report of the Chairman's Task Force on Service Delivery and Vocational Rehabilitation expressed profound concern, with respect to OWCI, about duplication of costs, and it recommended a review of the contractual agreement with the WCB.

The task force, although impressed by the design, calibre of scientific staff and advisers, and research proposed by the OWCI, has concern about the arrangements with the WCB. There is great value in longitudinal studies on occupational health. These studies are the most accurate and meaningful of all research tools and should be used as a basis for policy development. However, concern has been expressed that the research proposed by the OWCI extends beyond the mandate in its contract[26]. Also, the accountability relationship for such a large budget is of great concern, especially when there is so little money devoted to occupational health and compensation research in general.

Analysis

An examination of the research for identifying occupational disease involves research in occupational health. Hence, an issue to be resolved is whether the research needed for occupational health is the same as that for compensation purposes. Occupational health research involves a search for an increased risk to health from exposure to particular agents or conditions of work, or particular types of work. The task force believes that the underlying research is the same and that research should always focus on prevention. However, due to the different needs of the occupational health and compensation systems, the use made of the data may be different.

One reason for the perceived need for different research for compensation purposes is the urgency for an answer. Another reason that the two 'types' of research have been separated is the competing interests of those sponsoring the research.

Occupational health research is often more 'basic'. The studies tend to be scientifically rigorous and more controlled. They are aimed at identifying hazardous agents and causal relationships with a view to prevention. Even so, often there seems to have been a reluctance to take action until relationships are 'proven'.

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[26] Note that the task force's analysis was based on the understanding that the research mandate of the OWCI was as quoted in the report.

It was impressed on the task force through its consultations that adjudicators have to make decisions based on the information that is available. They do not have the luxury of saying 'Maybe; we are awaiting scientific proof'. 'Yes' or 'no' are the only options and, as people's incomes are on hold and dependent upon the decision, the decision has to be made as accurately, fairly and quickly as possible.

For compensation purposes, the studies may be designed to answer the question: Is there an association of sufficient strength and significance to help an adjudicator determine whether a disease could be due to the nature of employment? Although such studies have been described as 'quick and dirty', and as not providing data that are definitive, the task force believes that such studies are necessary. They are important as indicators of high-risk situations, which, in turn, indicate the need for preventive initiatives, information to workers and further study to identify specific causal agents or conditions. A question that has to be answered is whether the findings were peculiar to that one group or the particular workplace studied, or whether the results can be generalized to other workers in other workplaces with similar conditions.

The task force holds the strong belief that the standard of proof required to initiate preventive strategies should be lower than that for identifying a relationship between work and a disease for the purposes of compensation. The standard of proof for determining that, on the balance of probabilities, work contributed to the development of a disease will be lower than strict scientific 'proof' of a causal relationship.

In summary, the task force believes that the same research is of value for both occupational health and compensation purposes.

What is needed

The task force recognized that in order to improve the system of identifying industrial diseases, there needs to be more and better co-ordinated research. The primary purpose of the research should be prevention and it focus on investigating whether or not there are causal relationships between exposure to particular agents or conditions of work and diseases or illnesses. Research needs include

a) collection and collation of information already available from international/national sources. This information should not be restricted to epidemiological studies, reports of clusters and case studies. It should include consideration of information on toxicological properties or mechanisms of actions of suspected hazardous agents or factors, animal studies and, if necessary, psychosocial indicators,
b) collection and collation of statistics,
c) primary research - studies.

The task force considers that occupational health and compensation research should be centralized. There needs to be co-ordination of research efforts, centralization of data collections, standards for quality assurance and mechanisms for peer review. There needs to be a mechanism for rationalizing the costs and focusing funds that are already being spent on occupational health and compensation research.

Ideally, all occupational health and compensation research in Canada should be co-ordinated through a central body, with close liaison with such bodies in other jurisdictions. However, as occupational health and workers' compensation are the responsibility of 13 different jurisdictions across Canada, the task force recognized that such a centralized body would be difficult to establish.

Considering the advantages of centralized research institutes, such as the National Institute of Occupational Safety and Health (NIOSH) in the United States, the Swedish Work Environment Centre and the Institut de Recherché en Santé et en Sécurité du Travail (IRSST) in Quebec, the task force initially proposed the establishment of a central research institute in Ontario. It was proposed that the institute be responsible for conducting primary research, collecting and collating scientific information from published literature and collecting and collating statistics from the various input agencies involved with occupational health and safety and compensation.

When the task force presented the details of the proposal at the focus group meeting, many questions and concerns were raised. The task force took careful note of the concerns and spent considerable time reconsidering. One of the recommendations from the discussions was that the task force investigate other such institutes and develop the concept more fully. Although the task force agreed with the need, neither its mandate nor its resources allowed for this option.

Therefore, the approach taken was to identify the fundamental issues that need to be addressed and recommend a mechanism for addressing them, recognizing that the details of implementation will require further study.

The following are the essential features of reform for the system for occupational health and compensation research. There must be

- a centralized mandate and responsibility for research in occupational health and compensation issues
- research capacity in occupational health and compensation issues in Ontario, to include:
    - primary research
    - collection, collation and review of scientific information from published literature and other jurisdictions
    - collection, collation and analysis of relevant statistics
- a mechanism for appropriate peer review and for ensuring the quality of research and reviews

- a means of co-ordinating and integrating research functions and data
- a means of rationalizing the costs, reducing duplication and establishing priorities
- fiscal responsibility to the funding agencies, but independence from political interference in the performance of the research
- a centralized 'clearing house' for the information and for liaison with like institutes, institutions and government bodies, provincially, nationally and internationally
- a central core of expertise dedicated to occupational health.

Concerns about the initial proposal focused on three issues: the creation of 'yet another bureaucracy', the ability to set priorities with conflicting demands of occupational health and compensation, and the limited resources available.

The task force recognized the difficulties associated with setting priorities, especially when resources are limited. It also recognized that the questions asked and the use made of the data will be different for the purposes of occupational health from what they will be for compensation purposes. Therefore, it had proposed that there be a steering committee composed of the agencies responsible for developing, or affected by, policies in occupational health and workers' compensation.

Independent research is essential, as is the independence of researchers. However, to ensure that the best interests of worker health, safety and compensation are served by the funds being allocated for occupational health and compensation research, there has to be close links between the research function and policy development. For this reason, the model that the task force proposes for integrating and co-ordinating research and policy will be discussed in the following section under policy formation.

b) Collection and Collation of Statistics

Collection of statistics is an aspect of research that is often overlooked in favour of basic research. This has been a problem locally, nationally and internationally.

Present Situation

As noted earlier, there are initiatives to address the issue of collection and collation of statistics locally, with the establishment of the ODISS data base, and nationally, by a committee of Canadian Association of Administrators of Labour Legislation - Occupational Safety and Health (CAALL-OSH,), Workers' Compensation Boards and Commissions, and Statistics Canada.

In 1992 a group was set up

> To establish an up-to-date Canadian national standard for the recording of work related injury and illness information which will provide a sound framework for classifying injury and illness data, and which will permit the collection and dissemination of complete and integrated statistics, useful to persons interested in occupational health and safety.

The need for such a system was identified many years ago and noted by Weiler[27] in 1983. Following a recommendation by the Federal Provincial Advisory Committee on Environmental and Occupational Health, a working group was specifically directed, among other things, to

- examine WCB and similar data bases to identify ways and means to promote compatible systems including the promotion of standard and uniform coding system and to add variables to those data bases
- to examine the collaboration with Health and Welfare Canada, the feasibility of adding occupational information to existing health data bases
- to investigate the possibility of data base linkages.

There were a number of recommendations from the working group, including one that CAALL, in association with the National Health Information Council (NHIC), ensure that pan-Canadian co-ordination is pursued in developing surveillance of occupational illness. Specific areas for immediate action included i) standardization of data collection and coding, ii) identification of minimum set of data elements, and iii) information sharing mechanisms.

Concerns

Persons attempting to access WCB statistics have been continually frustrated by the lack of standardization and the changing coding systems. The changes that are made and the different purposes for collecting the information have made it very difficult to determine trends. This is particularly true for industrial diseases.

The task force found many anomalies in the information it obtained and a great deal of inconsistency between the information obtained from different sources and that obtained from different data systems within the WCB.

Many of the difficulties with collecting and collating statistics are quite specific and have to do with basic differences in the systems in place, definitions and the purposes for collecting the information. The task force applauds the initiative of the Ontario WCB in establishing ODISS and its outreach for suggestions on how to structure the data base to

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[27] Weiler, P.C. Protecting the Worker from Disability: Challenges for the Eighties. A report submitted to Russell H. Ramsay, Minister of Labour (Toronto: Ontario Ministry of Labour), April 1983.

make it most useful. However, it is aware that concern has been expressed that the collection of such information could be a major undertaking, and it appears that some employers have questioned whether the funding should be entirely from the WCB.

Analysis

Comprehensive data bases are difficult to establish, especially if the questions to be asked of the data are not clear. Attempts to match data with statistics gathered for other purposes are complicated by a lack of recognition of 'employment' as an important variable. Another problem is that certain diseases may not be the primary cause of death or disability. Often people with disabling lung diseases die of heart failure. Death certificates would list heart failure as cause of death. In the case of industrial disease it is not clear which medical conditions are included as diseases and which as injuries or disablements.

The ODISS system is used to collect and collate information on the claims that are adjudicated by the CCU-D. This means that some disease claims will not be included, e.g. noise-induced hearing loss, a number of dermatitis cases and other claims adjudicated in the regional integrated service units. The information retrieved from ODISS is very different from the statistics published by the WCB or that retrieved from System 57 (the main WCB data base). Coding of information under ODISS commences by determining the general nature or category of the claim, such as malignancy, respiratory, cardiovascular disease, etc. (see headings in Table 2). Then the information extracted from the claim form(s) and/or files is coded under four major headings: administrative, personal, accident history and medical. A reasonably large number of variables are included so that sorting can be achieved within the system when the questions to be asked of it are more clearly enunciated.

Ontario has been fortunate in having reasonably comprehensive information on miners. This was a result of a requirement in the mining regulations under the Occupational Health and Safety Act that miners undergo routine surveillance in the form of chest X-rays. Records were kept and they form the Miners Master File. Analysis of this data has been the basis for a number of mining policies.

What is needed

The task force emphasizes the importance of integrating WCB statistics with information from such other sources as cancer registries, hospital records, registration of deaths, etc. This information should be co-ordinated at a national level by Statistics Canada and at a provincial level through a government agency since it involves a number of different government departments.

There has to be consistent coding and harmonization with systems of record-keeping in other Canadian jurisdictions and, as much as possible, other international jurisdictions. The co-ordination of WCB statistics should be mediated by the Association of WCBs, and it should link with the information collated by Statistics Canada.

To improve the collection and accessibility of information on occupational diseases, physicians should be required to register all cases of occupational disease. This could be done by requiring physicians to note all cases of occupational disease on their bills for service to the Ontario Health Insurance Plan (OHIP). As OHIP seeks reimbursement from the WCB for all workers' compensation cases, the WCB could collect and collate the information. This registry should be separate from, but linked to, ODISS. Since the determination of work relatedness and compensability follows an investigation by the WCB, the figures and information in the two data bases will be quite different. Caution will be required in interpreting the information; however, links to other health records through OHIP will be most useful. The requirement to register occupational disease cases would also serve to increase awareness and allow for the detection of trends or of associations to particular areas or workplaces.

There should also be a requirement to include occupation in other health records and the cancer registry.

As disease cases/files are not straightforward, coding the information in any system presents a variety of problems. There needs to be flexibility in the system. Because there are so many variables, coding can be effective only when persons entering information into the system understand it. For example, a file may contain a specific diagnosis, but no information about whether the disease is malignant. It is not clear whether lung cancers are always classified as malignancies or whether they could be classified as diseases of the respiratory system.

There should be a clear definition of the information required from the files. A committee of experts should be convened to advise the WCB of the types of variables that should be coded into the system. This should take into consideration the information that is required to conduct a meaningful analysis, to identify trends and, if necessary, to form the basis for epidemiological studies.

Recommendations

#13 that a committee be established to determine the specific needs for data bases like the Occupational Disease Information Surveillance System (ODISS). The committee should include a member from the Industrial Disease Standards Panel (IDSP), the adjudication unit of the WCB, the corporate data section of the WCB, the policy body for research, a biostatistician from an academic institution, a member representing labour and one representing management.

#14 that the committee (recommended in #13) have a time-limited mandate to recommend structure and content of the information to be collected for the ODISS data base to ensure its usefulness for analysis.

#15 that the WCB and the Ministry of Labour continue to promote national initiatives towards standardizing the coding system for occupational diseases.

#16 that physicians be required to identify all occupational diseases on their Ontario Health Insurance Plan (OHIP) billings and that the WCB establish a registry of occupational diseases from this information.

C. POLICY DEVELOPMENT

This section deals primarily with the process of policy development. The details of policy content evolve from a discussion of adjudication, and as is emphasized throughout this report, the purpose of the policies and design of the system are to aid adjudicators in decision making.

Two levels of policies that need slightly different processes for development will be considered in this section: 1) general guiding principles, and 2) specific policies. There are two types of specific policies: reactive and proactive.

1. General Guiding Principles

Guiding principles are general principles that should be developed by the Board of Directors to guide the administration of the Act. These should cover such issues as the legal tests that are used, the criteria for scheduling a disease, etc.

It was the task force's mandate to examine the principles underlying the approach of the WCB to the adjudication of occupational disease claims. The task force interpreted this to be an examination of the guiding principles.

Present Situation

As far as the task force could establish, there are no guiding principles clearly enunciated by the Board of Directors. An examination of specific policies and operations indicates certain approaches that have become institutionalized. In 1990-1 there was talk of the Board issuing a discussion paper on occupational diseases, which presumably would have identified issues and proposed solutions and a generic approach to adjudication of occupational diseases. It seems that as the minister's task force had been proposed, and then was established, there was a decision to await the task force's recommendations before proceeding.

Concerns

The lack of clearly enunciated guiding principles is a concern to those within the system: those developing guidelines and policies as well as adjudicators having to make the decisions. It is also a major concern to the clients of the system since it is unclear what is to be covered, what standards are being applied and what legal tests are being used.

The task force believes that many of the concerns with the other components of the system are due to the lack of clearly enunciated guiding principles.

Analysis

The task force identified guiding principles as the critical fulcrum on which the whole adjudication system balances. The lack of clarity on these principles, while the source of many of the problems, is partly an inevitable result of the intractable nature of the issue.

Unfortunately, many of the guiding principles for adjudication of occupational disease claims, although general for many diseases, need to be quite specific in their focus. Flexibility is needed and this may explain why there has been a reluctance by both the WCB and the IDSP to specify or recommend such principles. Another explanation for the apparent lack of guiding principles is that there has been a tendency to deal with occupational disease issues on an ad hoc basis. They have never represented a large proportion of the claims to the WCB. They were also very varied, therefore not a priority. Initially, diseases that were considered compensable were listed in the schedule, and this was based largely on the list developed by the International Labour Organization (ILO), meaning that no guiding principles about when to add diseases were developed. As the need for policies for other diseases was recognized, information was sought for specific diseases. These were often quite different, hence the need for general principles was not evident. Only with experience were similarities seen and the need for consistency and a standard approach was recognized.

However, as well as principles to guide policies and adjudication of occupational diseases, there also appeared to be a lack of principles guiding the process. For instance, there still appears to be some confusion over the role of adjudicators, the legal tests to be used, the role of physicians in decision making, the role of policies, who develops them and whether they differ from guidelines.

What is needed

There is an urgent need for guiding principles which are clearly enunciated and communicated within the WCB and to the affected parties. The mechanism for setting **policy direction** has to accommodate the needs and interests of the affected parties, ensure consistency with the legislation and be practical and accountable.

As the Board of Directors is accountable for administration of the Act, the Board must have the ultimate say in policy direction. It is suggested that the process of developing guiding principles be carried out in consultation with the various constituent groups and the body charged with developing specific policies.

The guiding principles should be derived directly from the legislation and be used to guide the development of specific policies to ensure that all are consistent with the Act.

Recommendations

#17 that the Board of Directors, in consultation with the body responsible for developing policy,[28] develop guiding principles for the adjudication of occupational disease claims.

#18 that the WCB ensures that the guiding principles be simply and clearly specified and communicated to adjudicators and clients of the system.

The task force, throughout its deliberations, focused on process and means of dealing with issues. Recommendations are made about the need for guiding principles, who should determine them, and the types of things to be considered. However, in the process of analysing the issues to determine how to improve the system, the task force came to some conclusions on what the principles should cover, and, in some cases, the content and nature of the principles. The specifics on the nature and content of the guiding principles are briefly discussed since they are elucidated in the analysis of adjudication. They form the basis for many of the recommendations. Conclusions on content were based on interpretation of the Act, and the recommendations represent a consensus among the members that the approach was fair and practical, and that any other approach would be contrary to the provisions of the legislation.

2. Specific Policies

Specific policies include the policies or guidelines that are determined for specific diseases. A typical policy should contain a description of the particular disease, its occurrence, information to be considered and guidance for determining entitlement. For example, a policy would contain information on diagnosis, possible causes, levels and duration of exposure that are associated with an increased risk for the disease, and the reliability and limitations of the data used to derive the figures.

This is the same information that is necessary to determine whether a disease should be scheduled. Although the general guiding principles should provide guidance for determining whether the information is sufficient for scheduling, the final decision will be one of specific policy development.

Present Situation

Originally, amendments to Schedule 3 required legislative approval, and only diseases on the schedule were compensable. In 1947 such changes were made as would allow diseases to be added to the schedule by regulation; that is, they would only need cabinet

[28] The body responsible for developing policy will be discussed in the next subsection

approval. Also, the definition of industrial disease was expanded. Since this time, few diseases have been added and 'new' diseases have tended to be recognized within the expanded definition by means of policies.

Development of policy has been a function of policy departments within the WCB, which then submit proposals to the Board of Directors for approval. Only recently, with the establishment of the IDSP and the consultation unit of the WCB, has there been the opportunity for consultation on proposed policies. Also, there is now a specific branch in the policy division of the WCB that is devoted to diseases: the Medical and Occupational Disease Policy (MODP) Branch. In 1992 the Board of Directors established a Policy and Planning Committee of the Board to oversee, monitor and direct the policy and planning agenda of the WCB.

Industrial Disease Standards Panel

In order to understand the mandate and intended function of the IDSP, the task force briefly reviewed the history of the development of the Panel.

Paul Weiler, in introducing the concept, stated

> In a world of inevitably limited knowledge, insisting on rigorous scientific backing for either general disease policies or adjudication of individual claims will inevitably tilt the balance against recognition of real occupational disease cases (as has been shown again and again by subsequent evolution of both scientific knowledge and the Board's guidelines themselves).
>
> To help facilitate the emergence of this rather different conception of compensable industrial diseases, there should be another actor in the field: an Industrial Disease Standards Panel.

The recommendations in the Royal Commission on Asbestos' (RCA) report for an Advisory Council on Industrial Disease Policy appear to be based on the recognized need for eligibility rules to structure the Board's discretion in the matter of industrial disease compensation. They note that the development of such rules places 'a premium on judgement'. They stated,

> We expressly wish to underline the importance we attach to these three functions by using the more formal term "eligibility rules" to encompass what the Board currently calls "guidelines". Especially because eligibility rules involve equity among citizens and constitute declarations of public policy, we urge that they should be determined by an open process. To be sure, openness may also enhance the technical quality of the rules in that a wider array of expert views may be brought to bear on their content. The contrary view is that openness will dilute the quality of the guidelines because they will be the outcome of

> conciliation between conflicting vested interests. Whatever the merits of these contending views, considerations of equity and public policy speak compellingly in favour of an open process.

Paul Weiler also noted the need for an open process, claiming that a closed system, like that used by the Board at that time, 'hides the fact that there is an inescapable policy dimension to compensation guidelines' (cannot be a matter solely of science) and 'deprives interested parties of any role in the standard-setting process.'

The Panel envisioned by Weiler had,

> as members, the kind of eminent medical specialists now regularly consulted by the Board. But it should also have a clinician, an industrial engineer and hygienist, a lawyer or someone else with experience in compensation adjudication.

Weiler advocated that the members be part-time, and, preferably, not be representatives of management and workers' groups. He noted that such groups should have the right to participate fully in the proceedings. 'But the ultimate judgements should not be the result of the tug of frankly partisan views.'

He went on to suggest that the Panel would primarily base its work on 'a review of the world-wide research literature. However, it should have a budget (coming from WCB assessments) with which it could commission an Ontario study when it believed such was necessary.' He proposed that the document put out by the panel would contain an analysis of the current knowledge and set out options with pros and cons. The interested parties could react, and opposing views could be exchanged and debated. The ultimate product would describe the relationship: if causal, the document would spell out specific criteria that should produce a strong presumption in favour of compensation. It was also Weiler's opinion that,

> the standards finally issued by the Panel should be the governing ones. They should be attached to the Act (as are the current Regulations and Schedule) and thus enjoy this degree of formality and accessibility.

It is interesting to contrast this to the composition recommended by the RCA and the reasons:

> The members should be representative of the views of labour, management, the public and the medical-scientific community. We specify this breadth of membership because the formulation of advice on industrial disease policy is as much a matter of pragmatic judgement as of scientific judgement. (p712)

They then go on to recommend that the Advisory Council have the authority to appoint expert panels. They suggested that the panels of medical-scientific experts 'would cause a study or studies to be undertaken by recognized specialists'. Also acknowledged is the need, both for an arm's-length relationship between the Advisory Council and the Board, and open linkages. Reasons cited for the linkages included the need for the Board to be able to request the initiation of contemplation of an eligibility rule and,

> as the rules are building blocks of industrial disease policy, they should not be divorced from first-hand knowledge of the overall policies and practices of the Board.

The IDSP, which was established in 1985 with the amendment to the Act, was probably a combination of the ideas of Weiler and the RCA, the membership to include 'persons representative of the public and of the scientific community and technical and professional persons'. Representatives of labour and management are not specified in the legislation but have always been included on the Panel. The functions are specified in the legislation:

(a) to investigate possible industrial diseases;
(b) to make findings as to whether a probable connection exists between a disease and an industrial process, trade or occupation in Ontario;
(c) to create, develop and revise criteria for the evaluation of claims respecting industrial diseases; and
(d) to advise on eligibility rules regarding compensation for claims respecting industrial diseases.

It is unclear whether this is the policy function recommended by the RCA. However, there is the provision for the Panel to appoint special panels 'to investigate matters arising out of its functions'. The implication is that these special panels would report on the 'science' in particular diseases. There is no mention of a budget for research. The Panel is required to report its 'findings' to the Board, and the Board, before accepting or rejecting any findings of the Panel, is required to publish a notice setting forth the nature of the findings and calling for comments. The Board may accept the findings of the Panel with or without amendments or may reject the findings but is required to publish notice in The Ontario Gazette with its reasons.

As the membership and mandate are relatively flexible and/or unclear, there have been mixed opinions and expectations of the Panel. Even the Chairs have had different interpretations, and there appears to be a change in direction of the Panel under the present chair.

Ison has written that[29] as the Panel has the legal mandate to advise on eligibility rules, and as the other subsections in s95 (then 86p) specify how the WCB should deal with the advice, 'thus for any new eligibility rule to be legally valid, it must be one which has been: (a) recommended by the Panel and accepted by the Board; or (b) recommended by the Panel, amended and then accepted by the Board.' However, this has not been the practice, and Ison's opinion has been questioned by Laskin,[30] among others.

The IDSP, under each of the three chairs has published reports and made recommendations to the WCB. The reports have been published in the Gazette, and public comment has been called for. Even in cases where the WCB has acted upon the issues raised by the IDSP, there have been considerable time delays and a great deal of discussion, especially within the WCB, with little indication and no stated reasons why the Board was not immediately accepting the recommendations. It appears as though, in some cases, there were questions about the scientific validity of the findings that led to extensive investigation. At times, further studies were conducted. The Medical and Occupational Disease Policy Branch has devoted a great deal of time analysing and responding to the recommendations of the IDSP. It appears as though there is considerable duplication of effort between the two groups, both of which are staffed with a number of highly qualified people.

Concerns

The concerns expressed about policy development include concerns about the mandate and function of the IDSP. Therefore, all will be dealt with together and are included in the following abbreviated list.

- Schedules are outdated; they need review and are being replaced by policies. These and other concerns about schedules have been discussed above.
- The approach of developing policies instead of adding diseases to the schedule has avoided the decision about when, what, and how to schedule.
- Avoiding scheduling has also meant that workers are not provided with the benefit of the presumption in s134(9).
- The development of policies appears to have been relatively ad hoc: a mixture of reactive and proactive with no guiding principles being apparent.
- Eligibility rules and criteria are being used to exclude injured worker's claims from case-by-case adjudication.
- Some industrial diseases, silicosis and pneumoconiosis, are referred to in the Act, which puts them in a different 'category'.

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[29] cite footnote 21

[30] Laskin, J.I. in a Commentary on Compensation for Industrial Disease under the Workers' Compensation Act of Ontario. by T.G. Ison. prepared for and issued for discussion purposes by the Industrial Disease Standards Panel, September 1989.

- There are no appropriate means of determining which diseases need investigations and/or policies, whether policies are proactive or reactive or whose needs are being addressed.
- There is confusion over policy direction. It is unclear whether there are underlying principles, and, if so, what they are, who sets them, and who should set them: the Board or the IDSP.
- The role of the IDSP and the MODP are unclear and appear to overlap.
- There is too much political influence over the policies.
- There is no, or insufficient meaningful, consultation with affected parties, and little, if any, opportunity to provide input.
- The needs of adjudicators are not being considered, either in type or content of the policies being developed.
- The WCB has been virtually immobilized by the IDSP's reports. Possible reasons for this include,
  - criticisms of the scientific quality of the studies and interpretations used as a basis for the reports/ recommendations,
  - negative comments received from affected parties when the reports have been Gazetted,
  - the recommendations or actions implied by the reports are considered, by the WCB, to be too expensive, impractical or politically unpopular.

  This situation has resulted in considerable time and effort being devoted to analysing, critiquing and reinvestigating the areas covered by the IDSP reports. In some cases, issues have been referred back to the IDSP. This has been described as searching for reasons not to implement the recommendations and cited by some as the reason for establishing the MODP. Whatever the case, the situation that has developed is adversarial and counterproductive. It has diverted resources from developing and reviewing policies and responding to requests from adjudicators for technical advice or information on specific issues.
- Concern that WCAT is setting policy.

Analysis

The task force ascribes many of the problems encountered in the adjudication process to the lack of clearly defined guiding principles and policies. However, it understands that this lack of policies is also due, at least in part, to the intractable problems of occupational illnesses. As noted in the list of concerns, there is considerable confusion and overlapping functions in the area of policy development. The task force, in trying to understand the present situation, looked at how it emerged and attempted to identify the reasons and problems encountered. However, this process will not be described.

Instead, due to the critical importance of policies to aid adjudicators in their task, the task force's approach was to determine what is needed, and then decide how best to achieve the objectives within the present system.

First and foremost, the task force recognizes that it is the role and responsibility of the Board of Directors of the WCB to administer the Act and ensure that all policies and procedures are consistent with the requirements of the Act. The Board has the right to set its own operating policies, and, because it has the responsibility, it must have the final say in policy formation.

When determining the process for policy development, other factors also need to be taken into consideration.

- Often, the information relating diseases to work or employment factors is highly technical, but it also includes judgement. When judgement is involved, there is the potential for being influenced by bias.
- The Board, and, therefore, the administration, will be viewed as biased if analyses and interpretations of the technical information are performed internally by the WCB administration without adequate opportunity for external peer review.
- Policy development requires consideration of many factors other than 'pure science'. As well as accounting for difficulties with medical diagnoses, limitations of exposure data and work histories for individual workers, there needs to be consideration of legal interpretations, legal precedence, case law, practices and experiences in other jurisdictions.
- Decisions are public policy decisions and should be open to public comment, scrutiny, input and participation from affected parties.
- Because of the specialized nature of occupational disease issues and the small proportion of claims relative to injuries, occupational disease issues are not a high priority. Therefore, the experience and expertise among the public, labour and management are limited. For these reasons it is difficult to ensure meaningful participation from affected parties.

Before attempting to design/redesign a system for policy development, the task force identified the fundamental objectives. The system should ensure that,

. all policies are designed for achieving the purpose of aiding the adjudicator in determining the relationship between the adverse health effect and work
. all policies are consistent with the legislation
. priorities are set to ensure that the health and well being of the workers in Ontario are the prime consideration. Therefore, setting priorities should take into account the number of workers affected, the seriousness of the condition and the difficulties of adjudicating claims
. the best science is reviewed while ensuring that a lack of good scientific data does not preclude policy development if the condition is considered a priority
. technical experts oversee any research that is considered necessary to perform
. there is a mechanism ensuring appropriate peer review for scientific research, reviews and interpretations

- as far as possible, the scientific/research function is separated from the policy development, such that the arguments about the quality of the science on which the policy is based should occur before policy development and among scientists. It should not occur between policy makers at the WCB, the IDSP and critics from the affected parties. The fact that a policy is unpopular does not mean that the science should be questioned
- there is collection of other relevant information, such as legal precedents, relevant statistics, need for policy and potential impact
- the information and interpretations are open to the affected parties
- there is involvement of the affected parties in the decision making process
- there is an opportunity for public input.

The role of WCAT in determining policy was a concern expressed to the task force by many employers. As noted earlier, WCAT does not have a direct role in policy formation and is not bound by legal precedents. However, the task force believes that it has served a very useful function in continually analysing the legislation and in questioning the Board's interpretation and the legality and implementation of policies and practices. If in the opinion of the tribunal any discrepancies are found, these are laid out in detail, with reasons, in the reports of the decisions communicated to the Board. It is then up to the Board to determine whether it considers that a review under S93 (previously 86n) is warranted. Therefore, though not a direct role in policy formation or an aid to adjudication, it is an important 'quality assurance check' or audit for the system. It can help identify or indicate future trends by identifying situations where the policies and guidelines are not adequate to deal with the complexity of newly identified conditions. Although the task force believes this to be an essential function, it wishes to clarify that it should not be relied on as a means of detecting future trends, new diseases, or reviewing the adequacy of policies and guidelines for dealing with industrial disease adjudication. The fact that WCAT's decisions are reviewed by the adjudicators is seen as setting precedents and influencing policy. However, the analyses of the decisions are performed by WCAT for the primary purpose of determining whether they are consistent with the legislation. This is an important function and should always be the prime consideration of policy development.

The task force reiterates that the purpose of the policies is to aid adjudicators determine entitlement consistent with the legislation: nothing more and nothing less.

The role of the IDSP in policy development has been controversial. Many, especially employers and some occupational physicians and scientists, consider that the role of an external body, in this case the IDSP, should be strictly scientific. The role of a strictly scientific body would be to evaluate studies and to advise the Board of Directors whether there is sufficient evidence of a causal relationship to classify a disease as an occupational disease, and to identify/specify criteria indicating when the causal relationship applies. However, considering the limitations of the scientific information and the evidence that it can provide, it is recognized that these determinations cannot be

made on science alone. Judgement is required in the interpretations of the data, in determining what constitutes 'sufficient' evidence, and in knowing where to draw the line with criteria. The judgements needed are not scientific; they are public policy and based on the legislation. Therefore, the task force concluded that it is not the role of scientists to make these decisions.

It appears that, originally, the IDSP was perceived to be, or intended to be, a purely scientific body. Perhaps one of the problems has been the difficulties experienced trying to make the decisions on 'science alone' without the acknowledgement of the public policy elements. Under the present chair there has been a movement away from 'science alone', and one towards a more public policy model with a strengthening of the links to constituent groups.

It is speculated that if the IDSP were to play a role in policy development, it would be in proactive policy. As the history of the IDSP's involvement in the process has been mixed, and confused by the WCB's lack of response to it, the task force decided to consider not how it does fit in, but how a body like the IDSP could/should fit into the system.

The task force recognized that the process of policy development could, and that in the minds of many it should, be performed by the WCB. Although the task force agreed not to speculate on the reasons for the present situation and how the confusion over roles and responsibilities developed, it is obvious that there were considerable problems when policy development was the sole domain of the WCB. Some have suggested that the fact that there were problems with the way the WCB fulfilled its role does not mean that the function should be delegated to another body. Instead, they suggest, problems should be identified and rectified within the WCB. The task force still considers this an option. The recent efforts by the MODP in collecting information, reviewing information and initiatives from other jurisdictions, preparing position papers or policy proposals, and involving affected parties have indicated great improvements in the WCB's approach to policy development. However, no policy directions have emerged and few specific policies have been approved. Difficulties with delays in having policies approved and circulated to affected parties could be partially explained by the lack of guiding principles or by their not being clearly enunciated. Other difficulties in getting policies approved could include the confusion over roles and the establishment of a new committee of the Board of Directors to oversee planning and policy. It appears as though the MODP could serve an important function in responding to requests from adjudicators for information and direction, and, perhaps, in the development of reactive policy.

Although the efforts to involve affected parties in the development of specific policies have been commendable, such efforts will only be feasible on issues that involve large companies and large unions that have, and can afford to devote, the time and resources to such initiatives. It is recognized that such specialized groups will not always be available, and that when they are, they will consist of different individuals, which will make continuity and consistency difficult.

On the other hand, the task force noted the great advantages of having an external body with representatives of management and labour and technical experts dedicated to reviewing the information available, determining the priorities for policy development, and the needs for further information. A body such as the IDSP provides for social dimensions of policy development to be taken into consideration and openly debated. It also allows for focusing expertise from outside the WCB, with the advantage that a group can accumulate experience. This should promote consistency of approach. Because the IDSP has a legislated mandate, it has accountability for its decisions. However, it seems as though the IDSP's arm's-length relationship with the WCB has caused a number of problems. The interests of the affected parties are critical to the development of fair, acceptable policy; but the interests of the WCB, especially that of the adjudicators, are also essential considerations. Just as it is important for the constituent groups to feel comfortable with the fairness of the policy developing process, and, gradually, with the fairness of the policies, so too must the WCB feel comfortable. It is the Board that is responsible for administering the Act, and policies are only tools for facilitating the process. Therefore, there needs to be trust/credibility between the WCB and the IDSP. A concern expressed by employers is the need for financial accountability: Should the WCB be expected to enact policies that it considers impractical or not based on the best information, scientific or otherwise? If responses to the IDSP's proposals, when published, are negative, should the WCB go ahead anyway? For these reasons the task force considers that if there is to be an external body like the IDSP involved in policy development, it is essential that there be closer links to the WCB.

A number of options for closer links between the WCB and the IDSP were explored, including,

- having members of the Board of Directors as members of the Panel
- having a senior executive from the WCB administration sit on or attend meetings of the IDSP
- having the chair of the IDSP as an ex-officio member of the Board of Directors
- involving adjudicators with the IDSP
- convening regular joint meetings between the Board of Directors (BOD), or a committee, and the IDSP
- a bipartite executive with closer links to the Board.

To deal with the issue of credibility/trust and financial accountability, the best solution seemed to be to have a Board member representing labour and one representing employers as Panel members. However, there are a number of disadvantages to this option including the amount of time part-time members can devote to such activities, the difficulty of getting sufficient expertise and interest from the Board when occupational disease represents a small proportion of the WCB's overall caseload and the potential for the Board to dominate the priority setting. Board members should only be one of the interests considered in the priority and policy developing decisions. There is also the potential for conflict of interest for members who are part of the process of developing policies as well as the body reviewing and approving them. The IDSP, itself, also expressed concern at mandating appointment of BOD members to the Panel, although in some circumstances it was seen as an advantage. The task force considered that if BOD members were to be members of the IDSP, there should be equal representation from employers and labour.

Efforts in the past to have meetings between the staff of the WCB and the IDSP have not been successful at resolving the difficulties.

Adjudicators should be involved in the process; however, it was considered inappropriate and impractical that any WCB staff be Panel members.

Therefore, following an analysis of the options, the task force concluded that, although noting that it is essential that there be closer links between the IDSP and the WCB (both BOD and staff), perhaps the two governing bodies should convene a meeting to determine what would be the most effective means of liaison. Joint meetings once or twice a year would be an advantage regardless of which option is chosen, and the task force considers that the chair of the IDSP should be invited to attend meetings of the BOD when IDSP recommendations are being introduced.

While not directly addressing the issue of links between IDSP and WCB, the task force considered that a bipartite executive of the panel would have a number of advantages. The proposal is that there be a full-time vice-chair representing employers, one representing labour, and a neutral chair. The rest of the panel members would be part-time and have expertise in the various technical specialities. The members and the chair should be acceptable both to employers and labour and be appointed by Order in Council. Such a composition would allow consideration of the social and public policy aspects of the decisions as well as the scientific basis, and would be responsible to the constituents.

With the present structure of the IDSP, it is difficult for the representatives of labour and management to be representative of, and responsible to, their constituents. This is partly due to time constraints, limited resources and the limited number of people with sufficient expertise to devote to the complex process. It is particularly difficult for employers because their constituent groups often have very different views and opinions,

and limited networks. Therefore, the task force considered one of the main advantages of having full-time vice-chairs would be to have a person within both management and labour that could be

- devoted to occupational disease issues
- responsible to their constituents for bringing concerns to the table for discussion
- responsible for communicating information back to constituents and for general networking
- responsible for interactions with their counterparts on the Board of Directors of the WCB and other relevant agencies.

There is no doubt that this structure would have the effect of politicizing the IDSP. However, if the IDSP is to be developing policy, it is appropriate and, some would say, necessary to be a political body. The task force recognized that there will be criticisms of the proposal, such as

- the body will be too politicized
- 'another bipartite body', and examples of problems making decisions or reaching consensus will be cited. Some suggest that the body should be tripartite with scientists, lawyers, physicians and personnel with relevant technical expertise, and the public constituting the third part. Such expertise has to be represented on the Panel; however, it is likely that in reality it will be chosen with the intention of trying to balance the 'biases'. Whichever method is used to select the expertise, the task force suggests that the potential for bias and the need for judgement be recognized and openly debated.
- 'then there will need to be staff specifically to advise each "caucus"'. The task force believes that the staff should be there to support the Panel and the process, and should be acceptable and responsible to the executive. This should also prevent issues from being debated and 'decided' at the staff level.

The task force recognized that somewhat different processes may be needed for reactive and proactive policies.

Reactive policy would be developed to meet the immediate needs of an adjudicator faced with a problem. Thus the need for reactive policy will be when the information on a specific disease and the conditions under which it is likely to be caused by work factors is insufficient to make a decision. Proactive policy would be developed when the body responsible for policy development is alerted to an association between a particular work/work factor and adverse health effects. Such information may come from a variety of sources and would need investigating. If the body considered that there was sufficient evidence for concern, it would initiate policy development and alert the affected parties to the concern.

What is needed

Therefore, in summary, there needs to be a mechanism for developing specific policies that involves

- affected parties in the decision making
- a means of setting priorities
- critical analysis of the scientific information and interpretations with provision for appropriate peer review
- quality control to ensure that the decisions are based on the best available information
- adequate opportunity for input and meaningful consultations
- consideration of, and ensuring consistency with, the intent of the Act and the guiding principles.

It was pointed out to the task force that these functions could and should be performed by the WCB.

The task force has reviewed the mandate and composition of the IDSP, and recognizes the value of such a body being responsible for developing specific policies. However, to avoid some of the problems with the present system, the task force considers it essential that

- the IDSP have an advisory role to the Board on the nature and content of the guiding principles
- it be clarified that the IDSP has the responsibility for developing specific policies for occupational diseases subject to approval by the BOD of the WCB
- the IDSP be responsible for taking into consideration the comments from the public, co-ordinating the participation of the affected parties, and making changes as appropriate
- the IDSP be responsible for the quality of the information and interpretations used as a basis for the policies
- the IDSP has the responsibility to Gazette proposed policies, along with the rationale
- there be direct links with the WCB to ensure that the concerns of the Board and the needs of the adjudicators are taken into consideration in the process of policy development
- there be a requirement for the WCB to publish its response to the IDSP's recommendations along with a time frame for implementation or reasons why it does not intend to implement the recommendations
- the role of the WCB in approving or rejecting the policies developed by the IDSP be that of a governing body with ultimate accountability. It needs to ensure that the policies are consistent with the policy directions that it has established

- the Panel have a full-time executive consisting of a neutral chair, a vice-chair representing labour and a vice-chair representing employers. Other panel members should be part-time and have expertise in the various technical specialties.

If these changes are made, the role of the IDSP will be clear, and it will be both unnecessary and counterproductive for the WCB to have a policy department devoted to reviewing the scientific bases and decision-making process of the IDSP. The accountability for the process of developing policies for occupational diseases should rest with the Panel. If this is not to be the case, or if there is not a level of trust in the quality and fairness of the policies, there is no point in continuing to have the IDSP perform these functions, and the Act should be amended accordingly.

It is anticipated that these changes will decrease the time delays in adopting and implementing policies. By being required to make the responses public, the affected parties will know and understand the reasons and have direct access to the Panel. With time, this should facilitate the process of developing fair and practical policies.

Recommendations regarding the IDSP

#19 that the IDSP have an advisory role to the Board on the nature and content of the guiding principles for occupational disease adjudication.

#20 that it be clarified that the IDSP has the mandate to
- **review and advise on updating Schedule 3 on an ongoing basis,**
- **develop specific policies for occupational diseases,**
- **Gazette proposed policies along with rationale,**
- **consider input from affected parties and make changes as appropriate.**

#21 that the IDSP be made responsible for the quality of the information and interpretations used as the basis for the policies.

#22 that there be direct links with the WCB to ensure that the concerns of the Board and the needs of the adjudicators are taken into consideration in the process of, and in setting priorities for, policy development.

#23 that the IDSP have a full-time executive consisting of a neutral chair, a vice-chair representing labour and a vice-chair representing employers, and part-time members with expertise in the relevant technical specialties that are acceptable to employers and labour.

#24 that it be clearly stated that the role of the WCB in approving or rejecting the policies developed by the IDSP be that of a governing body with ultimate accountability.

#25 that there be a requirement for the WCB to publish its response to the IDSP's recommendations along with a time frame for implementation or reasons why it does not intend to implement the recommendations.

The following scenario is described to illustrate how the policy development process is envisioned to work both for reactive and proactive policies.

For reactive policy, the adjudicator, faced with a difficult problem and insufficient information would investigate the information available on the disease, with guidance from technical support, and the specifics of the individual claim in order to make a decision on a case-by-case basis. When a second claim arises, the information would be re-examined, there would be a determination of whether there was any new information on the disease, and whether the specific conditions could be compared. Probably the second, and subsequent, decision would be guided by, or at least be made in consideration of, the previous decision. There is a need to have some consistency. Depending on the disease, it is likely that further claims would stimulate the desire to have guidelines. Guidelines should be summaries of the available information and the way decision principles should be applied in individual cases. Such guidelines should be developed within the unit with the help of the technical support staff, but basically by and for the adjudicators. **Remember the purpose of policies is to aid adjudicators to make difficult decisions as expeditiously and consistently as possible. The desire is that decisions be based on the best information available, be consistent with the intent of the Act (and the guiding principles determined by the WCB), and defensible.** When there is concern or uncertainty (a need for a 'comfort level'), there should be a request for policy direction.

3. <u>The role of the IDSP</u>

1) Reactive policy. The IDSP should review guidelines developed within the adjudication unit and
   - add more information as appropriate
   - determine whether the application of decision principles is consistent with the guiding principles laid down by the Board
   - determine whether to formalize the guidelines in the form of policies or to add the disease to the schedule
   - keep constituents informed and facilitate input into the process.

2) Proactive policy development. The IDSP should
   - identify areas for new policies. This would involve communication with constituents, including workers groups, occupational physicians, the Ministry of Labour and anyone with concerns about possible links between disease and work

- review scientific literature (toxicological as well as epidemiological studies) and initiatives in other jurisdictions
- determine whether there is sufficient evidence to propose a policy and/or whether further study is required either as literature searches or scientific studies
- propose policy, determine the form that is best to help adjudicators, seek public input, modify as needed and recommend policy to the WCB.

The decision about the structure of the IDSP was made considering the essential features of function. Policy has to be

- consistent with the guiding principles of the WCB
- consistent with the Act
- based on the best science available
- credible. The process has to be open to the affected parties to ensure that it is realistic, fair and acceptable.

4. Model for Integrating Research and Policy Development

As noted in the section on Identification of Occupational Disease, there is need for

- more and better research
- a centralized mandate and responsibility for occupational health and compensation research
- research capacity to include
  - primary research
  - collection, collation and review of scientific information from published literature and other jurisdictions
  - collection, collation and analysis of relevant statistics
- a mechanism for
  - appropriate peer review and ensuring the quality of research and reviews
  - co-ordinating and integrating research functions and data
- fiscal responsibility
- a centralized clearing house for information and liaison
- a central core of expertise dedicated to occupational health.

It was also noted that, as far as possible, the research should be separated from the political influences of policy development. However, if funds are allocated for research to support policy development, there must be a means of setting priorities that includes consideration of the best interests of the health and safety of Ontario workers.

It was considering all these factors that the task force proposed the model to integrate the functions of the various organizations and agencies involved in research and policy formation illustrated in Figure 5.

The system consists of the following

1. A central research body: an occupational health research centre. This should be responsible for co-ordinating research, collecting and collating scientific information from published literature and collecting and collating statistics from the various agencies involved with occupational health and safety and compensation. The centre should have a scientific secretariat with expertise in, or direct access to expertise in epidemiology, toxicology, biostatistics, occupational hygiene, occupational medicine, ergonomics and psycho-social aspects of health. There should be close liaison with academic institutions. In order to maintain high academic standards and liaison, it is suggested that some scientific staff be cross-appointed from universities. There should be collaboration with the Ministry of Labour laboratories and public health laboratories to share resources and facilities where appropriate. There should be links to national bodies, like the Canadian Centre for Occupational Health and Safety, Labour Canada, Statistics Canada and the Association of WCBs. Also, there need to be links to international organizations, such as the ILO and the World Health Organization (WHO), and equivalent organizations in other jurisdictions, notably NIOSH in the USA, the Swedish Work Environment Centre and the IRSST in Quebec. There should be communication with, or links to, other major research groups in industry and consulting companies, as well as agencies and government departments responsible for collecting and collating statistics.

2. An external scientific advisory committee. This should be responsible for the scientific quality of the work performed and for ensuring that there is thorough peer review when necessary. As the expertise in occupational health and compensation research is limited, many of the scientists in Ontario may be performing work for the centre or be directly associated with it. For this reason it is suggested that the scientific advisory committee consist of specialists in occupational health from outside Ontario. If this is not feasible, there should be strict guidelines to prevent conflict of interest situations from arising.

3. A steering committee. The steering committee should be equivalent to a Board of Directors, and be responsible for determining the priorities for the research to be conducted.

It should be composed of stakeholder members from the various input agencies, specifically labour and employer members from the bodies charged with developing policies for occupational health and for compensation, e.g. the Workplace Health and Safety Agency, the WCB and the IDSP.

The steering committee should determine its own procedure for priority setting, but must take into consideration

- the feasibility of studies, including a cost benefit analysis and the ability of the study to answer the questions asked
- the importance of the topic to the health of Ontario workers

- the likelihood that the results of the study will lead to actions that will improve the health and safety of workers.

The steering committee should be responsible for the relative allocation of funds and be accountable to the funding agencies.

The funding should be derived from

- existing sources for occupational health and compensation research. These include the money from the Ministry of Labour and the WCB that is currently being used to support, directly or indirectly, occupational health and compensation research, as well as the grants program currently used for research.
- external sources. However, there would need to be considerable care to avoid conflict of interest. For example, if companies want a particular substance or work process investigated, and are willing to fund the study, quality assurance and scientific independence should be maintained.
- government and private sector funding to support the collections and collation of relevant statistics.

Proposed Functioning of the System

Indications for investigations should come from the same variety of sources identified in the section on recognition of occupational disease. Important sources within the occupational health and compensation systems are information from workplace inspections by the Ministry of Labour and observed clusters or problems from adjudicators at the WCB. These should be channelled through the respective agency to the steering committee. Proposals or recommendations from employer or labour groups or joint health and safety committees could go through either the Workplace Health and Safety Agency or the IDSP, or through their constituents directly to the steering committee.

The indications of concern or proposals for investigation should be reviewed and should possibly undergo initial screening prior to being brought to the steering committee. The steering committee should thoroughly review the information and determine what sort of research is needed. It may need scientific or legal literature to be searched, analyses of statistics, contact with other jurisdictions or, less often, research studies. One of the great advantages of a central system is that this process will be known to all the groups likely to be involved. Therefore, there can be communication, co-ordination of effort and avoidance of duplication, and development of expertise at a centralized accessible location.

The steering committee must determine priorities according to well identified criteria. The criteria have to be based on an assessment of the need and importance of the study

contributing to the improvement of the health and well being of Ontario workers. Therefore, once the approach to a particular study has been identified, the decision will be made whether it should be investigated, who should do it and how it should be funded. Some literature searches may be performed by the individual agency. The agencies have the resources and the knowledge base already. However, there would be considerable advantages to having such literature searches co-ordinated through the centre. This could allow for the sharing of expertise and resources between constituent agencies. It should also ensure that the appropriate peer reviews are conducted.

The scientific advisory committee may have input on study design if primary research is considered necessary. The steering committee should be responsible for approving the funding. If 'primary' research studies are approved, they would be contracted out. Proposals would be reviewed by the scientific secretariat, who would submit recommendations to the steering committee for approving contracts. The scientific advisory committee would be responsible for reviewing the scientific quality of all such work.

There should be every effort towards co-ordination and communication between the researchers being funded through the system and the scientific secretariat. All research proposals for funding, as well as final reports, should be written in an easily understandable form. The assumptions that are made at the beginning and those that are needed throughout the work should be clearly stated at the outset. There should be a clear statement about the effect the assumptions have, or are likely to have, on the results. The limitations of the study and the areas where judgement and opinion are needed, and/or used, should also be clearly specified.

Following study completion and peer review, the results of the study would be presented to the steering committee. As far as possible, study results should only be interpreted for their 'scientific meaning', noting the limitations and areas where judgements are made. It is up to the scientific advisory committee or study team to explain the study and results. The steering committee would then provide the information to the respective agencies to be used as the basis for policy formation. For example, the IDSP could use the information to help determine the conditions at which workers are at increased risk. This would allow the Panel to develop policy guidelines to guide adjudication. Such policies and/or guidelines would be submitted to the Board for approval and implementation according to the scheme outlined above.

The task force recommends that the experiences of similar organizations in other jurisdictions be reviewed prior to finalizing the administrative and organizational details for the research centre, scientific advisory committee, and the steering committee. However, when the details are worked out and agreed to, the contract and memoranda of agreement between the funding agencies and the central research body must clearly specify accountability and responsibilities. The mandate for the research centre should be legislated.

The task force recognized that there will still be criticisms and challenges posed by such a scheme. These include

- the challenge to not create another bureaucratic structure
- ensuring that existing resources are utilized and incorporated
- the difficulties determining priorities when certain research studies are required for political reasons. There will have to be arrangements to deal with issues specific to the MOL or the WCB, such as evaluation of rehabilitation strategies used by WCB clinics or investigation of specific workplaces
- pressures on the steering committee in determining priorities and allocating limited research funds. It is of prime importance to ensure that this does not lead to an immobilization of the system
- efforts will have to be devoted to prevent adversarial relationships between the various agencies. It will also be necessary to ensure that this does not lead to the establishment of departments to criticize (evaluate) the studies. It will be essential that there be trust, accountability and co-ordination at the level of the steering committee.

Implementation of this scheme will require

- legislative amendments
  - i) to clarify the mandate and specify the structure of the IDSP
  - ii) to create the research centre and clearly identify its mandate,
- development of a mechanism for amending the contract with the Ontario Workers' Compensation Institute and for integrating the functions and personnel into the research centre.
- deploying the expertise presently in the MODP to support functions for the adjudication process.

Advantages

This system will

- allow rationalization of research funds
- ensure that all research has undergone thorough review for its relevance and usefulness of data for the health and well being of Ontario workers
- allow discussion of the science, its adequacy and limitations, to occur at the scientific level and separate from the policy groups
- provide a mechanism for quality control of the scientific information
- allow closer links between research and policy development
- provide policy developers with the best information available
- provide a 'centre' and co-ordinating body for developing expertise, the collection of information and for communication with other research bodies

- allow for communication between policy developing bodies in occupational health (through the steering committee)
- promote research and policy development towards prevention.

Recommendations for an Integrated System of Research and Policy Development

#26 that an occupational health research centre be established.

#27 that the functions of the centre include co-ordinating primary research, collecting and collating scientific information from published literature and collecting and collating statistics from the various input agencies involved with occupational health and safety and compensation.

#28 that the centre have a scientific secretariat with expertise in, or access to expertise in, epidemiology, toxicology, biostatistics, occupational hygiene, occupational medicine, ergonomics and psycho-social dimensions of health.

The research centre should have close liaison with academic institutions. In order to maintain high academic standards and liaison, it is suggested that the scientific staff be cross- appointed to universities or other centres of relevant expertise. The report identifies the types of links and interactions such a centre should have, nationally and internationally, and suggests that, in the long term, a national institute should be established.

#29 that the centre have a scientific advisory committee to audit the scientific quality of the work performed and to ensure that studies are thoroughly peer reviewed.

#30 that the centre be governed by a steering committee composed of stakeholder members from the various input agencies, specifically bodies/agencies charged with developing policies for occupational health and for compensation, e.g. the Workplace Health and Safety Agency, the WCB and the IDSP.

#31 that the steering committee be responsible for determining the priorities for the research to be conducted and criteria to be used, but must take into consideration

- **the feasibility of studies, including the ability to answer the questions asked**
- **the importance of the topic to the health of Ontario workers, and**
- **the likelihood that the results of the study will lead to actions that will improve the health and safety of workers.**

#32 that the steering committee be responsible for the allocation of funds and be accountable to the funding agencies.

#33 that the funding for the institute and the research fund be derived from existing sources of occupational health and compensation research.

#34 that the experiences of occupational health research institutes in other jurisdictions be reviewed prior to finalizing the administrative and organizational details for the research centre, the scientific advisory committee and the steering committee.

However when the details are worked out and agreed to,

#35 that the contract and memoranda of agreement between the funding agencies and the occupational health research centre clearly specify accountability and responsibilities.

#36 that the research centre have a legislated mandate.

#37 that, at the time Recommendation #26 is implemented, arrangements be made to integrate the functions and personnel of the Ontario Workers' Compensation Institute into the occupational health research centre.

D. ADJUDICATION MODEL

Adjudicators act for the Board in making decisions as to whether, for a particular claim, the worker is entitled to compensation under the Act, i.e. whether the claim should be accepted or denied.

There are two aspects of adjudication: determining entitlement and determining benefits. The task force dealt only with issues surrounding adjudication for entitlement.

As discussed earlier, entitlement for diseases can be determined on the basis of the diseases fitting the definition of 1) an industrial disease in section 1, then applying section 134, or 2) a disablement according to the definition of an accident in section 1, then applying the other sections that apply for an injury by accident. Theoretically, the questions asked will be different for the two alternatives and different presumptions will apply.

Present System

At present, diseases, unlike injuries, are mostly adjudicated in a centralized unit in the head office in Toronto: the Complex Case Unit - Diseases (CCU-D). However, some diseases like noise-induced hearing loss and some claims for dermatitis are adjudicated in the regional integrated service units (ISUs). The mandate statement for the CCU-D is,

> Provide effective, efficient services to workers with occupational diseases and to the dependants of workers for all work-related fatalities. High quality services are provided province wide through a specialized and integrated team approach.

The unit consists of adjudicators, full-time and part-time medical consultants, nurses, a vocational rehabilitation specialist and case workers, an industrial hygienist, field investigators and support staff. It receives up to 400 new cases a month.

The following is a generic description of the process, and Figure 6 is a schematic representation of the types of information sought and the process used in making a decision. There will be differences depending on the nature and specific details of the case. Some will be a lot simpler and others will require more information and investigation.

Forms 6,7 and 8 submitted by the worker, employer and examining physician respectively should provide information on employment history, diagnosis of disease and impairment. Further information is sought by field investigators, who may visit the workplace and talk with the affected parties. If necessary, medical records are sought. All the information is assembled by the adjudicator, who then refers the case to an occupational medical consultant (OMC). Sometimes the file will be accompanied by specific questions for the

OMC. The OMC does not examine the worker, but may consider that further examination is necessary to confirm the diagnosis. If so, the worker may be presented with a list of doctors or specialists from which he or she can choose. Reports from these doctors/specialists will be considered and included as part of the OMC report to the adjudicator. The OMCs, as well as confirming the diagnosis and determining impairment, may seek information on workplace conditions or exposures. There is an industrial hygienist attached to the group that is part of the CCU-D. Information from the Ministry of Labour regarding findings or exposure measures from the ministry's records of investigations may also be sought through this group (OMCs). The report of the OMC and, if appropriate, a report from the industrial hygienist, is forwarded to the adjudicator with either answers to the adjudicator's questions and/or an opinion as to whether the disease was work-related (due to the nature of employment).

Once the adjudicator has assembled all the information/evidence, there are three possible scenarios for the adjudicator making the decision (see Figure 7 for an illustrative example of the process, as interpreted by the task force):

1) The diagnosis is consistent with a scheduled disease. In this case, the next question is whether the employment history is consistent with the occupations/processes listed in Column 2; and finally, whether there is any reason to believe that the disease was not due to the nature of employment.

2) The disease is not on the schedule, but there is a policy. Policies or guidelines often indicate the type and extent of work or exposures that could cause or contribute to the development of the disease. In this case, the questions are similar to those above. The adjudicator has to decide whether the diagnosis is consistent with the disease, whether the work history meets the criteria and whether there is any reason to believe that the disease was not work related. However, in these cases a lot of weight is put on the work history for measures of length and extent of exposures. Often, the available information is not sufficient or accurate enough to make a decision. As the disease may have a long latent period, the information sought may be about conditions 20 years before. The workplace may no longer exist. There may be attempts to estimate exposures or work conditions by retrospective exposure assessments. There will be discussion of the difficulties with such estimates in the Analysis section. Considerable judgement is required for these decisions.

3) The disease is not scheduled and there are no policies or guidelines. Such claims have to be adjudicated on a case-by-case basis, either as an industrial disease or as a disablement. The first question is whether the disease fits the definition of an industrial disease and, if it does, whether it was due to the nature of any employment. Alternatively, the question is whether it could be considered a disablement arising out of and in the course of employment. Whether or not the disease fits the definition of industrial disease is often dependent upon the results of group data.

Concerns

Some of the concerns that were expressed to the task force are listed below:

1) The process of adjudication is not consistent. The reasons or problems cited include,
- lack of information or 'scientific' data such as epidemiological or other studies to indicate whether disease can be/is likely to be associated with work. This can be that either there is a lack of information or the information is not available to adjudicators. This is a generic problem for all claims for a variety of diseases
- lack of, or poor quality, information on exposure and work histories, conditions of work, etc. Also, there can be severe limitations with information derived from exposure assessments, especially retrospective assessments. These problems are different from claim to claim
- lack of, or inadequate, investigations
- adjudication does not start from a 'neutral position'. Concerns on this issue were from both employers and labour; the adjudicator was cited as seeking evidence either to accept the claim (pro worker) or reject it (pro employer)
- that there are a variety of approaches: schedules, policies, guidelines, case-by-case adjudication
- lack of guiding principles for adjudicators
  - what is(are) the question(s) to be asked? - Did the work cause the disability? 'Could-does-did' triad? Did the work contribute to the disability? How likely is it that the work increased the risk of disease in that worker? Could the work have caused/contributed to the disability? On the balance of probabilities .. ?
  - what is significant contribution?
  - how to rebut a presumption
  - is a presumption different from the benefit of the doubt? A further concern in this area is that, even though the benefit of the doubt is to be given to the worker, the difference in the outcome of the decisions is largely influenced by the political will of the governing body at the time.
  - how much weight should be put on personal/lifestyle factors, especially in multicausal conditions?
  - role of epidemiological studies (group data) in adjudicating individual cases. The worker already has the illness/disability.

2) Burden of proof is too stringent. This was a concern cited by labour and injured workers. In some cases, employers expressed the concern that the burden of proof was not stringent enough.
- The scientific data are insufficient, and there is the need to rely on epidemiological studies.

- TLVs, in many cases, are not based on good scientific data. Concern was expressed at the weight put on TLVs for assessing whether the worker was exposed to an increased risk of developing adverse health effects.
- Too much weight is put on the exposure measurements/ assessments.

3) The process is too slow.
- The need for consistency and 'fast tracking' means that the adjudicators are pressured and do not have sufficient time to collect and carefully analyse all the evidence for each case.

The concern over timeliness is very important because ill workers need compensation as soon as possible. However, time is required to thoroughly investigate a claim. There is a concern that not all the information is made available to the adjudicators. This could be because the information was not sought, that worker or employer advocates are not brought in until the claim is appealed, or that parties do not think it 'necessary' to provide detailed information until the claim is appealed. Decisions that are made with inadequate investigation are often appealed. This causes considerable delays and frustrations. Adversarial relationships develop between the worker, WCB and/or employer. If the appeal gets to WCAT, there are more delays. There is duplication of effort, especially as investigations are also conducted by worker and employer advocates. A concern was expressed about WCAT being able to admit new evidence. The feeling is that the investigations should have occurred prior to the initial WCB decision. It new evidence is uncovered during the appeal process, the case should go back to primary adjudication at the WCB for review.

4) The process is too adversarial.
- perceived by employers as favouring workers
- injured workers, especially in areas outside Toronto, expressed concern at centralization. They considered that adjudicators were not approachable and that the quality of information expected exceeded the resources available, especially in the more remote areas of the province.

5) Concern about the role, training and availability of various advisers: medical, industrial hygiene, toxicology, epidemiology.
- that the roles are not clearly identified. It is not always clear that the adjudicator has the responsibility for the decision. There has been concern that the occupational medical consultants (OMCs) make the decisions.
- that the advice of other specialists in the field, such as toxicologists and epidemiologists, is not always readily available to the adjudicators.

Injured workers expressed concern at the lack of weight put on the opinion of the examining physician. Such physicians are familiar with the worker and his or her personal history and often/may be familiar with the conditions at the workplace. However, others, especially employers, view the worker's physician as an advocate for the

worker wanting the best for his/her patient. Concern was also expressed that physicians may give an opinion that a disease is work-related fearing that otherwise the patient will seek another, more favourable, opinion. General practitioners are considered to have inadequate knowledge of occupational health and medicine to be making decisions about whether a disease is work-related. On the other hand, OMCs do not see the worker, and, in many cases, do not see patients, so are criticized for not understanding the conditions.

6) Training of adjudicators is inadequate. This was a commonly voiced concern. It appeared to many that adjudicators had no special training, and are ill-prepared for their difficult task. Although the concern was mostly about adjudicators in general (in the ISUs), the greater problems and challenges of adjudicating occupational disease claims was considered to need special, intensive training. Adjudicators acknowledge the difficulties of interpreting the information they receive, especially the medical opinions. Therefore, they tend to rely on the advice of the physicians who make decisions according to the 'medical model'. The concern about the medical model is that the standard of proof is scientific and not necessarily consistent with the legal requirement. For an analysis of this issue, see Ison.[31]

7) That the appeal system is driving the adjudication by setting precedents. A concern expressed by employers was that WCAT decisions, even though they may not be 'officially' used in policy development, influence adjudicators in their decisions.

Analysis

The process of adjudication is based on a search for evidence of a causal relationship between work and the illness. The overall question is 'On the balance of probabilities did the worker's employment make a significant contribution to the development of the disease?'

For the purposes of this analysis the issues are divided into:

1) Evidence that work could cause the disease
2) Evidence on the individual circumstances that influence the likelihood that work did cause the disease
3) How to ascribe weight to evidence in cases of uncertainty
4) The legal test - What constitutes a significant contribution

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[31] Ison, T.G. Compensation for Industrial Disease Under the Workers' Compensation Act of Ontario. issued for discussion purposes by IDSP, September 1989. pp 24-28.

1. Evidence that work could cause the disease

The concerns about the lack of, or inadequacy of, information are similar to those discussed in the previous sections on identification of industrial disease and policy formation.

The approach taken by the task force can be summarized as follows. If 1) correcting/ controlling for other variables, there is sufficient information to indicate a statistically significant increase in incidence of the disease associated with a particular condition of work: and 2) considering the Bradford Hill criteria, there is the indication that the association is likely to be a causal relationship, then that exposure or condition should be considered a possible causative factor.

Most studies generating such data will include information on duration, level and nature of exposure that are associated with, or necessary for, the increased incidence to be manifested. Also, there is usually information about length of time between exposure and diagnosis or manifestation of symptoms (commonly called latency period). This information will often be used to estimate conditions/situations that are not likely to be associated with an increased incidence of the disease. For example, when exposures are too low, too short, or too recent to be likely to be associated with an increased risk. This is the way that eligibility rules, or 'criteria' have been established.
This approach, as well as guidelines on how and when it should be applied, should be among the guiding principles and clearly stated by the Board. In cases like the one described, where there is a statistically significant increased incidence and, considering the Bradford Hill criteria, evidence that the association is consistent with a causal relationship, the information would be sufficient for developing specific policies and/or scheduling, and for 'criteria' to be specified. These are the types of aides or tools that adjudicators need to help them make fair and equitable decisions. It has been the case that if a worker with disease x can meet the eligibility rules, he/she is entitled to compensation.

Usually, however, the data are weaker and the policies and guidelines can only contain summaries of the information that is available and the factors that need to be considered.

2. Evidence on the individual circumstances that influence the likelihood that work did cause the disease

In the scenario described above, the 'criteria' identify the type of information that needs to be sought to support the likelihood that the disease in that individual was caused by work or work factors. However, as well as limitations in the data, and estimates that led to the estimation of the conditions specified as criteria, there is also a lot of uncertainty associated with the information on conditions and exposures at work for individual claims. Often, there is a need to rely on retrospective exposure assessments. As noted

above, such estimates are fraught with difficulties. Many factors have to be considered, and there is considerable uncertainty, and often dispute, about the results. This is especially difficult when the information about health effects at various exposure levels is also very inadequate. For example, there needs to be consideration of variations in types of exposures, whether they are intermittent, continuous, or of variable concentrations, the physical nature, whether the exposures can be used as indicators of the absorbed dose, whether there is accumulation of the agent or of the effect, and variations in the effect on different individuals. Appendix 3 contains some information on these problems. The assessments have to be made and considered along with all the other information available.

The cases that appear to cause the greatest concern to adjudicators are those for which there are no policies or guidelines. This usually means that there is either a lack of information or uncertainty in the available information. Diseases that are known to have a number of causes are most difficult. The concerns listed above probably all apply to multicausal diseases. For example, there is uncertainty of information, difficulty determining the role of advisers, adjudicators need training and help to understand and weigh the available information.

3. How to ascribe weight to evidence in cases of uncertainty

This issue really has two components: a) When is there sufficient quality evidence to move from a possible cause to a probable cause? and b) Particularly in the case of multicausal diseases where there may be more than one probable cause, what evidence is needed to determine that the contribution made by work is significant to the development of the disease?

Some may rephrase the former as, ' What level of increased risk should be used to consider work a probable cause?' or simplistically, 'What Standardized Mortality Ratio/Rate (SMR) should be used as a threshold for recognizing the association between the work and the disease for the purposes of compensation?'

In the USA, the SMR value commonly considered the threshold is 200. This means that if the work increases the risk of developing the disease by a factor of two, the disease is considered to be related to work. Stated another way, it is considered to be work-related when there is a 50 per cent chance that work caused or contributed to the development of the disease, or when it is more probable than not that it did. This raises questions like - 'What about 190?' 'What do the figures really mean?' 'Why only mortality rates, what about morbidity rates?'

Guidance is needed to interpret the available data, and, often, epidemiological studies are the best of all that are available. The task force believes that while epidemiological studies are important, their power is more important than the numbers they generate. Statistical analyses help determine the weight to be put on SMR values but do not alter

the meaning or the strength of the association. The task force emphasizes that considerable caution needs to exercised in interpreting such data. It believes that there is a statistically significant increase in the risk when the 95 per cent confidence limits do not include an SMR of 100. Then, if the evidence supports a causal relationship, considering the Bradford Hill criteria (discussed earlier), the work should be considered a likely factor in the development of the disease.

The task force notes that this approach of relying on statistical analysis of epidemiological studies is very narrow and of limited use. As good epidemiological studies are difficult to perform, there is nearly always uncertainty about the results. Often, there is other information that, alone, is insufficient to draw conclusions. Sometimes the relevance of the information or how it can help determine whether there is a possible or probable causal relationship is not understood. However, it is essential that such information is considered. As discussed earlier, even for the purposes of developing policy, there should be consideration of other available information, such as observational information and evidence of clusters, as well as relevance and likelihood of alternative explanations. For case-by-case adjudication, the epidemiological studies and medical/scientific information, although important, should not be the only information considered. They are only parts of the evidence. Decisions should be based on <u>all</u> the evidence; entitlement decisions are based on a legal standard of proof.

4. <u>The legal test: What constitutes a significant contribution</u>

For multicausal diseases, where not all the causes are considered to be related to work, there needs to be a level of contribution by work factors that will be deemed to be sufficient to entitle the worker to compensation under the Act. This has been the crux of much of the dispute in disease claims. It appears as though, if not specified, the level or legal test is a significant, or material, contribution. Significant contribution is a term with which lawyers are reasonably comfortable, and in the Supreme Court of Canada decision (Snell v. Farrell), there is a recommendation that 'there be a robust and pragmatic approach to the evidence....' However, the medical and scientific communities are not as comfortable with the term 'significant contribution'. There is the belief that a level has to be specified. However, it is important to note that numerical specificity is not achievable even with the best data available. The approach taken by the task force was to recognize the importance of scientific research in understanding the possible nature of the relationship, but, when the decision has to be made, the limitations of science in identifying cause in an individual have to be recognized. The inadequate personal exposure data, the lack of precision in the dose/response curve, the limited knowledge about the mechanism of action are all limits of science.

Recognizing these difficulties, the task force asked: Would the process be any different or easier if the claims were adjudicated as disablements under the definition of 'accident'? In other words: Would it be easier to determine whether the disease or 'disablement' arose out of and in the course of employment?

Mechanisms for Structuring Decision Making

The task force recognized that the approach described above for identifying when policies and guidelines can be developed and used is simplistic, and that rarely are the data of sufficient quality for such conclusions to be drawn. For these reasons, there has to be a continuum of mechanisms depending on the amount and quality of the information that is available. Figure 8 illustrates such a continuum. When the data are considered 'sufficient', the disease should be scheduled. The schedule represents one end of the continuum. This is the mechanism of structuring decision making when there is the greatest degree of certainty of a causal relationship. However, with any multifactorial disease there will be cases where the work conditions or time of development of the disease will be such that the chance of the work factor(s) having contributed to the development of the disease will be so low as to be 'insignificant'. For this reason, and if there is to be a presumption associated with a scheduled disease, there should be some 'criteria'. However, the task force was very sensitive to the criticisms of the present system - the belief that criteria are 'rules' to exclude workers from entitlement. Instead, failure to meet criteria should be used, along with evidence of alternative hypotheses, as evidence towards rebutting the presumption. In other words, failure to meet criteria should mean that the claim will be adjudicated on its particular merits on a case-by-case basis.

As well as the data for determining criteria being inadequate, the basis for selecting them, especially in multifactorial diseases, is flawed. Even if there were good data and a definable dose-response relationship, criteria cannot distinguish between diseases caused by different factors. The fallacy of using criteria as a means of compensating only the excess is illustrated in Figure 9 in the endnotes.

For diseases where the data are insufficient, or are sufficiently uncertain, to schedule, there have to be policies and guidelines. The content of such guidelines has already been identified.

Recognizing that policies are not necessarily binding, but merely a framework for adjudicators to consider information specific to particular cases, should facilitate the policy-forming process. It should make it more efficient, in that policies will be less controversial and will therefore be developed in a more timely fashion. The policies

should better meet the needs of the adjudicators and should be easier to update as more information accumulates. The process will allow for more consistency without regimenting it, and allow adjudicators to make informed judgements considering all the relevant information for the particular case.

What is needed

1) General guiding principles should be clearly defined and available to adjudicators as well as to policy makers. Such principles need to be clearly enunciated and understood by the adjudicators so that they will 'guide' all decisions. Obviously, this is most important for cases where there are no specific policies. Also, guiding principles are the best way to allow flexibility within the limitations of the legislation and to provide for as much consistency in the decisions as is practical. Following consideration of the major issues, the task force suggests that the guiding principles should cover such issues as,

- the role of adjudicators as decision makers
- that decisions have to be in accordance with the Act
- the legal tests that apply, such as entitlement for benefits under the Act depends on determining, on the **balance of probabilities,** that the work made a **significant contribution** to the development of the disease and that the benefit of the doubt goes to the worker
- the types of evidence that should be considered in determining whether there is an association between a disease and a work factor; and whether the association is likely to be a causal relationship. An example would be that evidence not be restricted to epidemiological data and include consideration of Bradford Hill and other such criteria
- the purpose of specific policies is to guide adjudicators. They are not binding rules
- specific policies have to include information on the diseases, possible causes, conditions under which the factors are more likely to be causes, as well as clear indications of the uncertainty and limitations of the data. They should also contain the reasons for the policy, the factors considered and social implications.
- the fact that workers with multifactorial diseases are entitled to compensation if work/work factors make(s) a significant contribution to the development of the disease
- the type and level of evidence that will be considered sufficient to schedule a disease. For example, consideration of statistical significance and strength of association from epidemiological studies, and the weight to be attributed to toxicological studies and other findings. As there will always be a degree of uncertainty about the scientific information, and because the amount and type of data available will vary, these can only be guidelines
- recognition that, due to the limitations of the science, all the policies and scheduling are public policy decisions and should be made accordingly
- the basis for determining eligibility rules. For example, eligibility rules should not be based on only compensating the excess (see Figure 9 in the endnotes for an explanation)

- where exposure values or eligibility rules are included in guidelines, they only be used with full consideration of the limitations of the measures/estimates, and that they be used as 'bench marks'/standards for comparison when considering the exposures experienced by the worker.

2) More thorough investigations should be conducted. Every effort should be made by employer and worker representatives to decide the issue at primary adjudication level. The WCB should ensure that both adjudicators and the parties have the fullest possible access to relevant information.

3) More and better technical advice should be directly available to adjudicators in areas of toxicology and epidemiology. If, as proposed under the system for policy development, specific policies are developed by the IDSP, the expertise available in the MODP could be used to directly support the adjudicators. Such experts may be necessary to help 'translate' the specific policies, to ensure that they are clear and presented in simple language in the most useful form to aid adjudicators. This process of 'translation' should be done in consultation with the adjudicators so that the product best meets the adjudicator's needs while maintaining the specifics and basis of the policy recommended by the IDSP.

4) The role of advisers to the adjudicator should be clearly specified. Although the task force did not consider it necessary that a set of specific questions be created for the medical consultants, it emphasizes the importance of questions pertinent to the particular case being specified by the adjudicators. The technical/professional experts supporting the adjudicators should be trained to understand the needs of adjudicators, the type of information that will be useful as evidence, the limitations of the information, and how this will affect the weight of evidence within their own specialty. It must be emphasized that their role is to support (provide information to) the adjudicators and that it is the adjudicator that puts <u>all</u> the information from the various specialties together to make the decision. For an effective efficient system, the adjudicators have to have confidence in the information provided and in its relative weight. The supporting experts have to have confidence that the adjudicators understand the information.

4) Better training for adjudicators is needed. In the case of occupational disease, the information that has to be collected, understood and weighed is enormous and diverse. Adjudicators should have technical experts to help them. They need to have experience in the adjudication process and special training in issues important for diseases. They need an understanding of the various technical specialties and the terms used in medical diagnosis, industrial hygiene, toxicology, epidemiology, and legal process. They need to understand:

. the questions to ask of the technical support personnel
. how to interpret the responses
. how to fit all the evidence together to form the whole picture, and
. how to weigh the evidence relative to other evidence.

It is very important that adjudicators understand the reasons why it is not physicians and scientists making the decisions. They need to understand the level of proof - the requirements of the legislation, and that it is a legal test involving weighing all the evidence. The advice from the technical support has to be understandable to the adjudicator. The adjudicators for occupational disease should already have experience in adjudication, and undergo extensive training, both prior to adjudicating disease claims and on the job.

Consideration should be given to the possibility of developing a national training scheme for all adjudicators across the country. Obviously, this could only be used as a basis because the legislation and policies vary from one jurisdiction to another. However, there is an advantage for adjudicators to have the opportunity to interact with their counterparts in other jurisdictions, to upgrade their training and learn from the experience of others.

Summary and Recommendations for Adjudication

This section contains a description of the present scheme for adjudicating occupational disease claims and the concerns expressed to and by the task force.

In adjudication the issues that have to be considered at the level of an individual claim include

- evidence that the worker has an impairment or disability (diagnosis),
- evidence that work could have caused the disease,
- evidence on the individual circumstances that influence the likelihood that work did cause the disease,
- how to ascribe weight to evidence in cases of uncertainty,
- the legal test: what constitutes a significant contribution.

Key issues

- **that adjudication is the key function of the compensation system; therefore' the function of all other components should be related back to how it facilitates adjudication; therefore,**
- **adjudicators should be consulted and participate in decision making about the system,**
- the importance of Bradford Hill criteria in determining causal relationships,
- mechanisms for structuring decision making depend on the degree of uncertainty in the available information, therefore the need for a range of mechanisms that includes
    - schedules with a presumption when there is sufficient information and/or statistically significant data to make an association generalizable to exposed individuals even if it is only for certain conditions of exposure. The schedules should be accompanied by guidelines that indicate the conditions

under which the presumption of a causal relationship apply. The guidelines should emphasize that when the work conditions do not meet the 'criteria' (noting the limitations), cases should be adjudicated on their individual merits on a case-by-case basis

- policies/guidelines for specific medical conditions that list the available information and limitations
- general policies and guidelines that identify the process to be used in case-by-case adjudication. These would include guidance on weighing evidence and on determining what, 'on the balance of probabilities' constitutes a 'significant contribution' to the development of a disease.

Recommendations

#38 that the Board of Directors of the WCB, in consultation with the IDSP, develop guiding principles for the adjudication of occupational disease claims. The principles have to be consistent with the legislation and should include

- **the role of adjudicators as decision makers,**
- **that decisions have to be made in accordance with the Act,**
- **applicable legal tests, such as, that, on the balance of probabilities, the work made a significant contribution to the development of the disease, and that the benefit of the doubt goes to the worker,**
- **types of evidence that should be considered in determining causal relationships, e.g. that evidence not be restricted to epidemiological data and include consideration of Bradford Hill and other such criteria (see text),**
- **the fact that the purpose of specific policies is to guide adjudicators; they are not binding rules determining entitlement,**
- **type of information to be included in specific policies (see text),**
- **the fact that workers with multifactorial diseases are entitled to compensation if work (work factors) makes a significant contribution to the development of the disease,**
- **the type and level of evidence that will be considered sufficient to schedule a disease (see text),**
- **the fact that policies and scheduling are public policy decisions that, although based on the best scientific information available, need to take into consideration social dimensions,**
- **the basis for determining 'eligibility rules' or criteria, e.g. that criteria <u>not</u> be based on <u>only</u> compensating the excess (see text),**
- **where exposure values or criteria are included in guidelines, their limitations be noted.**

#39 that the guiding principles be simply and clearly specified and communicated to adjudicators.

#40 **that, within the adjudication unit, there be personnel with expertise in the fields of law, toxicology and epidemiology (as well as occupational medicine and occupational hygiene) to respond to the needs of adjudicators.**

#41 **that the personnel with technical/professional expertise supporting adjudicators**

- **be trained to understand their role in the adjudication process, the needs of adjudicators and the legal tests that the adjudicators have to apply,**
- **have the responsibility to respond to specific questions from adjudicators. Such responses should help adjudicators determine and understand the weight that should be put on individual pieces of evidence.**

#42 **that all technical/professional personnel supporting the adjudicators be encouraged to participate in activities to maintain their professional status and upgrade their skills and training on a regular basis.**

#43 **that resources be directed to developing guidelines to aid adjudicators interpret WCB policies that are developed for injury claims, but that also apply to diseases.**

#44 **that guidelines for adjudicators be developed with the active participation of adjudicators.**

#45 **that the special training for CCU-D adjudicators be reviewed. The issues to be covered in training include**

- **basic training in toxicology and mechanisms of disease causation,**
- **an understanding of the medical terms used, disease categories, etc,**
- **basis for industrial hygiene assessments, what exposure levels mean and their limitations,**
- **basic understanding of epidemiology and biostatistics, including the limitations,**
- **the Act, guiding principles and policies,**
- **legal standards of proof,**
- **case law, its interpretation and relevance,**
- **process of adjudication, and**
- **other such information thought important by the adjudicators.**

#46 **that the WCB, through the Association of WCBs, explore the feasibility of standardized basic training for adjudicators and establishing a means of communication between adjudicators in different jurisdictions.**

#47 **that there be a mechanism developed to ensure that adjudicators are kept up to date on policy development, recent workers compensation decisions, rules of evidence and relevant information from other jurisdictions.**

Timeliness, Consistency and Reduction of Appeals

The focus of this section has been on means of aiding adjudicators to make the best decision for each individual claim. Recognizing both the uncertainty and the complexity of the information needed, the decisions are often very difficult. In addition to the uncertainty about the cause of many diseases, each case needs careful consideration of the individual aspects of the claim: the diagnosis, the etiology of the disease, the workplace conditions and the confounding factors. Although policies and guidelines aid in the process and allow for a degree of consistency, flexibility is needed to allow for the individual aspects of the case.

The task force recognizes that even if all the changes recommended are implemented, decisions will still be difficult. Time will be needed for thorough investigations, and there will still be disputes about the decisions. In other words, not all the concerns listed will be resolved. However, it is anticipated that the adjudication process will be greatly facilitated when

- more diseases are added to the schedule
- meaningful guidelines are developed to aid adjudicators understand the nature of the evidence needed to rebut the presumption
- there are more specific policies
- the process for case-by-case adjudication is identified. General guidelines should clearly identify the information that needs to be collected and considered, and clarify the role of the adjudicator as decision-maker
- the decision rules are clearly specified
- there is more technical expertise available to respond to the questions and concerns of the adjudicators
- there is better communication.

Thorough investigations and better collaboration and communication between adjudicators and advisers, and adjudicators and affected parties should also help to resolve the issue at primary adjudication. The involvement of the parties and confidence in the process should reduce the number of appeals and, when there are appeals, the investigations by the worker and employer advocates as well as the appeal body or tribunal should be reduced. This should also resolve/avoid the issue of the tribunal admitting new evidence.

It is anticipated that increasing the number of diseases that are scheduled or listed with accompanying policies and guidelines will expedite the process of adjudication. This appears to be the experience in British Columbia, where most of the diseases are on a schedule and the process of adjudication is much faster.

From discussions with adjudicators in Ontario and other jurisdictions in Canada, it seems that lack of direction, clearly defined guiding principles, policies, guidelines, supporting technical advice and timeliness were their prime concerns and were areas they felt need addressing. The task force is convinced that the proposed changes will lead to

- more thorough investigations, more comprehensive, relevant information being sought and provided more expeditiously. It will be clear what information is needed at the beginning of the process
- faster decisions
- more consistent decisions
- less reason to appeal. The information requirements and decision process will be more standardized. People will understand the rules of the game.
- considerable savings to the system by more efficient, faster and fairer adjudication, fewer appeals and a reduction of duplication in the areas of policy development.

E. FUNDING

Present System

At present, industrial disease claims are funded in much the same way as injuries. For Schedule 1 employers, each rate group has its own account. The income for the account comes from the assessments levied on the employers in that rate group. The cost of claims are paid from the account. Until recently, like injuries, costs of occupational diseases were charged to the individual company's account for the purposes of experience rating (determining assessments under New Experimental Experience Rating (NEER) program) and penalty assessments. Although many diseases take a long time to develop, the cost of the claim is charged to the account of the last employer - the last employer where exposure occurred. Concern over this practice of charging the costs of disease claims to the last employer had been expressed and were the subject of several appeals. WCAT decisions 398/89 and 482/91 provide useful background on this issue. A quote from a discourse recorded in WCAT decision # 398/89 is of interest.

> 'It has been the Board's practice, therefore, to normally ascribe the costs of an industrial disease claim to the record of the last exposure employer. The employer's cost record is relevant to the purposes of experience rating and penalty assessment.'

It went on to state

> '... finally, apportionment of costs in industrial disease cases often presents major evidentiary difficulties in trying to determine retrospectively the length and extent of the worker's exposure during different employments and the different degree to which exposures may have contributed to the final disability.'

In the same document it was noted that the WCB recognized the need to review its application of s122(8) (now s134(8)). However, a similar decision (482/91) indicated that the practice of charging costs to the last exposure employer was still occurring.

There has been a Board policy since January 1987 to exclude from experience rating coverage the costs of claims for certain diseases with long latent periods, i.e. not charged to the accident cost statements of individual employers for the purposes of experience rating or penalty assessments.

There are two other WCB accounts that can be used to fund claims under certain circumstances. One is the Second Injury Enhancement Fund (SIEF), established to pay a portion of the claim that is considered to be a result of a pre-existing condition. This fund was established to encourage hiring workers with disabilities. It has the effect of spreading the costs over all industries covered under the Act. However, it is not used for industrial diseases except noise-induced hearing loss and white finger disease. The

reasoning is that these conditions may occur in a wide variety of employments. However, industrial diseases are, by definition, specific to a trade, process or occupation; therefore, it is considered an unfair burden to spread costs over industries where there is no exposure risk. A legal interpretation indicates that the SIEF should not be used to fund illnesses that can be attributed to prior exposures. The other fund that can be used in limited circumstances is the administrative fund. This has only occurred 1) after unsuccessful attempts to recover an overpayment, or 2) for costs resulting from an accident arising out of treatment.

From an analysis of section 134, it is clear that one of the main differences between the provisions for industrial disease claims and claims for injuries has to do with cost allocation. It appears as though this is based on the recognition that diseases can be slowly progressive or may have long latencies. Therefore, the allocation of the cost to the last employer is not always appropriate. This would cover charging the cost directly to Schedule 2 employers or to individual employer's accident records, for Schedule 1 employers. However, it appears that the provisions for sharing costs are rarely, if ever, used. For Schedule 1 employers, the WCB has the discretion whether to allocate the costs or part of the costs to other classes (s8(9). However, as the funding is organized through rate groups rather than classes, this provision has not been used for industrial disease. There are also provisions to allow for agreements with other jurisdictions in Canada to provide for apportionment of costs of claims for industrial diseases, for workers who have had exposure employment in more than one Canadian jurisdiction.

Concerns

1) Employers who are funding the system have grave concerns at the increasing costs in general. They consider that this will be exacerbated by compensating diseases of normal life, especially in times of fiscal restraint, a decreasing industry base from which to collect the funds, and an already high unfunded liability.

2) Another concern expressed was that funding many of the occupational disease claims moves away from the original intent of the Act: that the system was designed to compensate workers for injuries and illnesses that developed as a result of their work.

3) With increasing scientific knowledge and understanding of disease processes, one concern is that most diseases will be shown to have some degree of association with work and that if these are all to be compensated, the system will not be able to pay.

4) Many employers expressed the concern that it is unfair that they should have to pay the cost of full compensation for diseases when there is no certainty that the work caused it. In many cases, there may be no certainty that work was even a probable cause. There may be other probable causes that are associated with a worker's personal life or environment.

5) Emphasis on the cost of the system by employers, and, therefore, efforts to decrease or limit the number or type of diseases compensated, does not take into account the costs to the worker or the community as a whole of not compensating.

6) Some employers expressed concern at paying the cost of any disease claim that is due to a factor beyond the control of the employer. In other words, if, at the time the exposures occurred, there was no knowledge that the exposures were hazardous, or if lifestyle contributes to and/or increases the risk of a disease, the employer has no control, and therefore should not be held responsible for the costs.

7) Whether or not costs should be considered in determining policies was a concern to both employers and workers. Not surprisingly, employers considered that they should be considered, and workers considered that they should not be. Although there is a policy at the Board requiring a cost impact assessment for every new policy developed, workers maintain that if the disease can be shown to be due to the nature of a worker's employment, the Act requires the WCB to pay compensation to workers disabled by the disease. As this is specified in the Act, it is not at the discretion of the Board to make decisions about which policies to develop or which diseases to compensate, depending on cost impact to the system. Assessments of costs are important, though, in order to ensure that there is enough money in the system to pay the claims. It is important to estimate when more money needs to be paid into the system.

8) A number of concerns were expressed about cost allocation (or the lack thereof)

a) between companies. For example, there was concern that costs of claims for diseases with chronic onset or resulting from cumulative exposures are not distributed. It is unclear whether this is because Schedule 2 employers have not appealed or have not taken the necessary action specified in subsection 134(4).

b) between classes of industry or rate groups. Of particular concern were diseases with long latencies when the companies, which were the employers at the probable time the disease was 'caused' are no longer in business and the rate group is now very small. This means that the costs to that rate group could be very high, as in uranium mining, where the workforce is now 10 per cent of what it was 20 years ago and the cost of claims for lung cancer caused 20 years ago are having to be paid as payroll assessments by one remaining company with a small workforce.

c) between provinces. This was a concern that was raised at the task force's interjurisdictional meeting.

9) The practice of charging the cost of claims to the last 'exposure' employer's accident cost record has been considered very unfair for diseases with long latencies and those that develop over time.

10) There is no responsibility for employers to cover the eventuality of costs to the system after they have gone out of business. It was suggested that as there is a responsibility to clean up environmental pollution after the business has dissolved, surely there should be some provision for ensuring that there is a means of funding a disease legacy left by a company.

11) The means of determining assessments for a rate group depends on the accident record or experience of that group, rather than being based on risk. However, it is acknowledged that it is as difficult, or more difficult, to estimate risk as it is to anticipate what the experience will be for disease claims in the future. This makes the system essentially 'pay as you go' for diseases, with no means of providing for the future legacy of diseases.

Analysis

It was obvious to the task force from its meetings with employer groups that their major concern was the cost of the system. Many of their other concerns are motivated by a desire to prevent what they consider to be, an expansion of the scope of compensation. They wish to improve the efficiency of the system, while still maintaining a fair level of compensation for workers with injuries and illnesses that are directly attributable (scientifically proven) to employment. Cost is a major concern, and probably one of the main reasons that the system is so adversarial.

Although not within the task force's mandate, the means of funding the system had to be considered. There are two aspects to the issue of funding: 1) the generally high costs and unfunded liability; 2) whether the issues raised by occupational diseases present unique problems and costs.

1) Generally high costs and the need to improve efficiency and decrease duplication.

The analysis of the system of adjudication conducted by the task force was directed at improving the efficiency of the system, expediting the process, reducing unnecessary duplication and providing better and fairer adjudication so that there will be fewer appeals. These changes should lead to decreased costs.

2) Whether there are unique problems raised by occupational diseases that will affect the cost of the system.

The critical issues for the adjudication of occupational disease are the uncertainty about cause and the difficulties determining the contribution work made to the development of diseases commonly described as lifestyle diseases, or diseases of everyday life. There is no dispute that, at present, there is no way of determining with any certainty either the precise cause of many diseases or the degree to which work contributed to their development. It is not likely within the near future that these determinations will be

able to be made with any certainty. For this reason, many critics maintain that a system based on determining whether or not the disease or illness is due to the nature of the employment cannot work for occupational diseases. Many maintain that there is no such thing as an occupational disease. Although these problems are not entirely unique to diseases, they are common for diseases and less common for injuries.

How does this influence cost? The answer by many would be 'dramatically'. It depends where the line is drawn: How certain do you need to be that the cause was related to the work? How much contribution does there have to be from work before the worker will be deemed to be entitled to benefits under the Act? Obviously, if there is the requirement for 'scientific proof of causality' and if the contribution needs to be 'predominant', the costs to the system will not be very high. However, if there only needs to be a possible link, or association to work, and if 'any' contribution will be sufficient to entitle a worker to benefits, then the costs will be considerably higher. The concern over this later scenario is exacerbated by the knowledge that when there is more research, information on causality becomes more complex, not simpler. It is likely that links to work will be demonstrated/indicated in more and more diseases. Therefore, if entitlement to benefits is determined by work making <u>any</u> contribution, costs of occupational disease claims will increase. Employers fear that this will mean that the workers' compensation system will be paying benefits to most workers that develop a disease, even though the probability that it was caused by factors other than work may be quite high. Following this scenario through leads to the grave concern expressed by employers about whether the system (they) will be able to afford to pay. They also raise questions of fairness to employers if they cannot do anything about a worker's lifestyle or risks from outside the workplace. This is when the discussion becomes one of social policy and should also include whether it is fair not to compensate an ill worker who is working or has worked in an employment that increases his risk of getting the disease.

As stated and restated throughout this document, the task force was dealing with the process of adjudication of occupational disease under the <u>Workers' Compensation Act</u>. That is why the first task for the task force was to identify the purpose and intent of the Act. As noted, the task force concluded that the purpose was to provide compensation for workers in cases where work made a significant contribution to the development of the injury or illness.

Therefore, the approach could be that, while this is the law, the decisions have to be made on the best information possible to determine whether work made a significant contribution, and employers <u>have</u> to find a way to pay.

Discussion on how the money can be found could include questions about distribution of costs between employers: Are all employers paying into the system? Should there be a move away from the 'fault-based system' towards a more even distribution or collective liability? This alternative is based on the belief that employers in general have benefitted, directly or indirectly, from the labour, and therefore should share payment of

compensation for those disabled by the work. An alternative to fault or experience being the criterion for determining assessments, is the suggestion that the assessments be based on risk.

However, employers have expressed the concern that the present WCB system cannot afford to pay any more. Employers have proposed that there be no new policies on entitlement until the system has been 'cleaned up', and the general costs of the system are decreased. While the task force understands the need to increase efficiency, it points out that it would be illegal not to compensate for injuries or illnesses where a determination can be made that work made a significant contribution, regardless of whether there are policies or not. Although generally viewed differently, policies do not determine which diseases are compensable. Policies are only guides to the interpretation of the legislation; they cannot change the law.

The issue is that, if, as claimed by employers, the system cannot afford to pay, then either the system or the Act has to change.

The task force re-emphasizes that the system cannot be changed by changing the interpretation of the Act without changing the Act.
The recommendations thus far have dealt with improving the process of adjudicating occupational diseases claims. It is anticipated that these will increase the efficiency and, therefore, decrease costs. However, this will not solve the problems of funding and the fundamental dilemma of whether the present system is fair. These are social policy issues that have to be debated in a larger forum and in a broader context than the restricted mandate and resources of the task force.

However, even within the present system, there were some issues that the task force considered could, and should, be addressed.

1. Cost sharing between jurisdictions

From the interjurisdictional meeting conducted by the task force, it appears as though the issue of cost sharing between provinces is a problem, and that the provision in section 134 is hardly used. The task force was encouraged to note the proposed recommendations in the interjurisdictional agreement being considered by the Association of Workers' Compensation Boards. Among other things, the proposed agreement deals with the responsibility for adjudication and with payment for occupational diseases in workers with exposure employment in another or more than one Canadian jurisdiction.

Recommendation

#48 that the chair of the WCB develop an agreement with his or her counterparts in other jurisdictions in Canada on cost sharing for claims for occupational diseases with progressive onset or due to cumulative exposure when the exposure history of the worker includes more than one jurisdiction. This issue has to be resolved in such a way that the worker gets full benefit for the work related disability.

2. Whether or not to consider the cost of occupational disease claims against individual employer's records

The task force considers it inappropriate to charge the cost of industrial disease claims against the account of any one employer for the purposes of experience rating or penalty assessments.
Experience rating has been used as an incentive for prevention and a reward for good records. There is an ongoing debate about the advantages, disadvantages and value of experience-rating. Most of the issues pertinent to the debate are not unique to occupational disease. They are relevant to the intent of the system: whether it is based on fault and its effectiveness as an incentive for prevention. However, even supporters of experience-rating as an important mechanism for raising awareness of occupational health and safety and stimulating preventive initiatives recognize its limited application to occupational diseases. The long latency or delayed or gradual onset means that when the disease process was initiated, there was often no knowledge that there was an increased risk to the workers. Therefore, it is unlikely that preventive strategies could have been instituted, and it is unlikely that the workers were even working for the same company.

Concern was expressed that, even when not used for experience rating or penalty assessments, the claims still show on the company's 'accident record'. Accident records are often used for other purposes. Examples cited included management evaluation of safety and health personnel/departments and comparisons between companies in the same rate group. For these reasons, some employers are opposed to having occupational disease claims recorded in their account.

Recommendation

#49 that the cost of claims for occupational diseases with progressive onset or due to cumulative exposure not be charged to the accident record of individual employers for the purpose of experience rating and penalty assessments.

3. Means of allocating the costs of occupational disease claims

Present-day employers are paying the costs of compensation for diseases that may have been caused 20 or 30 years ago. As a means of easing this burden, it has been suggested that an attempt be made to anticipate the cost and location of the diseases that are being caused now but will not be manifest for many years. The plan would be to levy assessments accordingly and establish an occupational disease fund to meet the expenses when the diseases are manifested. Practically, it is virtually impossible to anticipate where diseases are likely to be caused. If such knowledge were available, it would be of primary importance to use it to ensure that preventive strategies are instituted. From present studies and trends, it appears as though the 'occupational diseases' of the future are unlikely to be confined to manufacturing and heavy industries. What happens if sufficient scientific data accumulates to indicate a causal link between use of video display terminals (VDTs) and some chronic disease in the operator, or perhaps, even in the fetus through fetal exposure?

With expanding medical information, knowledge about the links between work and the development of diseases will increase. With increasing awareness by workers and physicians, it is anticipated that the 'gap' between the number of work-related illnesses and the claims submitted will decrease. This does not necessarily mean that the number of diseases caused by work will increase, only that our understanding of disease causation will have improved. As it is extremely difficult to estimate the degree and scope of occupational disease, it is difficult to assess the present and future costs as well as any costs arising from the past.

Recommendation

#50 that a fairer method of allocating the costs of claims for occupational diseases with delayed onset be found.

The task force examined a number of options for improving the funding of the system. Amongst these were options to improve the allocation of costs within the present system, to slightly expand or alter the system, right through to options of developing a totally different system.

Options for Allocating the Costs of Occupational Diseases

1. A separate fund to cover the cost of occupational diseases

There are two main variations on this option: a) where the fund is established, in addition to the accident fund, by imposing a standard levy (flat rate assessment) on all employers in the system; or b) where the fund is a separate portion of the accident fund, derived from the fund as a proportion of the total assessment on each employer. In this

latter alternative employers with a high accident record and a high assessment would be paying more into the fund than employers with a low accident record and a lower assessment.

Because it is impossible to determine which employment situations are likely to cause diseases, the suggestion has been made that the fund be established by collecting a standard levy (flat rate) from all employers. Such a system would avoid the problems of, or need for, apportioning costs between employers and/or industry groups. It would be a step closer to a 'no-fault' system and more appropriate when it is difficult to assign cause, let alone fault. This could have the advantage of reducing appeals. Administrative expenses would be reduced by having a separate disease fund. There would be no need to separate costs of occupational disease from injuries for the purposes of experience rating, penalty assessments, and the determination of assessments. Such a scheme would tend to spread the cost of occupational disease more evenly among employers. The task force notes that, to some extent, the system is presently evolving in this direction. This is occurring because the unfunded liability is so high that the increase in assessments for most rate groups is nearing the maximum that is allowable under the rate stabilization scheme. Therefore, the extra costs are being spread across the accident fund as a whole. However, this has the effect of determining the levy as a proportion of the present assessment rather than as a flat levy and providing for a separate fund for occupational disease.

A number of concerns about this option have been raised:

- It will be an added cost to many employers who, at present, are claiming that there is no more money to go into the system.
- It would have the effect of spreading the cost more evenly among employers covered under the Act. This could be seen as a disadvantage to employers in classes that have had traditionally low disease rates, but as an advantage for employers in classes that have had high rates, like mining. It is interesting to note that, at present, the attempt to charge the cost of claims to the SEIF have basically had this effect. Some employers, those directly affected, see it as a way of removing the costs from their personal claims record and not pushing up their own assessments. While others recognize that it is still a cost to the system and not a way of dealing with the problem. That, however, depends on what the problem is: decreasing the cost of compensation or finding a fairer way of funding the compensation of industrial diseases.
- The fear expressed by employers is that such a system of collective liability and of spreading the costs over a larger base will only delay the process of addressing the real issue: Whether employers, through the workers' compensation system, should be paying the cost of compensating diseases where the links to employment are uncertain or tenuous, like diseases that have, to this point, been considered lifestyle diseases or diseases of everyday life.

- Schedule 2 employers are opposed to any form of collective liability both for injury and illness claims. The position of these employers is that they prefer the system as it is at present 'pay as you go'. There could be an option for those employers to remain on a system of individual liability. However, it would exacerbate the difficulties of allocating costs, especially if some of the exposure employers were Schedule 1 and others Schedule 2 and active use was made of s134(4).
- Whether it is fair that present-day employers pay the cost of yesterday's, today's and tomorrow's diseases, especially in times of an economic recession.

2. A separate occupational disease fund paid by ALL employers

Another variation on the above approach is to have a separate occupational disease fund but paid by all employers whether or not they are covered under the Act. This could be justified on the premise that large companies, especially banks, financial institutions and insurance companies, have benefitted from the manufacturing and heavy industries and should share the responsibility and costs of the effects that these industries have or have had on the workers. This would be especially true for industrial/occupational disease, where the effects are not immediately apparent, and, often, are not and have not been within the individual employer's ability to control. The advantages of and concerns about this scheme are much the same as those expressed for the first option. The greatest concern is that, while bringing in more money to the system, it would delay dealing with the 'real' issue of determining a better, more efficient means of drawing the line between occupational disease (caused by work) and diseases of normal life, which may be shown to have some connection with the workplace.

3. Supplementary benefit schemes

Another option is integrating, or supplementing, the workers' compensation system with other benefit schemes, such as long-term disability and pension schemes. For example, the present workers' compensation system would be retained for injuries and illnesses that are clearly and completely due to employment, and there would be a separate scheme or a variety of private schemes to cover disability for diseases or conditions where there is doubt about the cause or where the cause is partially or completely due to factors other than work. Many employers already have such schemes.

There are a number of variations for funding such a scheme(s): government or private; costs/premiums paid either by employers or with a contribution from workers through payroll deductions, or having cost distribution as part of an agreement between workers and employers and/or part of a benefits package. Some of the advantages of this proposal are

- compensation would be more widely available
- it would avoid many of the problems experienced in determining work-relatedness
- it would provide flexibility

- it would be fairer in that the workers whose claims have been denied by WCB, and those with disabilities not known to be work related, would get some income support
- depending on the system agreed to, it could apportion the costs between workers and employers for conditions that are less than completely work related. Some employers have expressed the opinion that if workers have to pay into the system, they are less likely to 'abuse' it
- it would provide alternatives to the bureaucratic structure of WCB. It was suggested that it could improve the administration of workers' compensation by making it more competitive with private insurers. However, this could also be cited as a potential disadvantage
- it would take pressures off physicians and adjudicators having to make judgement calls on the borderline and off adjudicators deciding the amount that work contributed to the disease, such as whether it is 'sufficient' to entitle an injured worker to benefits.

The difficulties and concerns with such an approach include:
- not all employers buy into such schemes; therefore, to be considered a fair, realistic option, it would have to be made compulsory
- the benefit levels are/would be lower than those presently offered by the workers' compensation system. Thus, there will still be an incentive to submit claims to the WCB and to appeal those denied, to see whether they can qualify for the higher benefits. So, although it could be viewed as a means of reducing the adversarial nature of the system, it is likely that, at least initially, it would not reduce the pressure on the system
- workers do not feel that they should be paying into a system to pay benefits for diseases that are at least partially work-related.

4. Proportional compensation

Such a scheme would pay partial benefits to workers whose disease was shown to be partially due to employment. This is based on the assumption that there can be a relatively accurate apportionment of cause between work and non-work. The advantages would include
- it would ease the concern of employers about paying for the costs of diseases that were not entirely due to employment
- workers with diseases that are partially related to their employment would not be in an 'all or none' situation. Hence it would be fairer.

The disadvantages and concerns of such a system of proportional compensation include
- the belief that it is not possible to apportion cause accurately or consistently. The basis for making decisions about the proportion of 'work relatedness' is epidemiological studies and other group data, which, for some diseases, can provide estimates of risk associated with certain factors. Such data, with

consideration of the statistical significance and strength of the association, can allow estimates of probability of causal relationships. Without going into an analysis of the methodology, there are concerns about the validity of using group data as a means of assigning individual risk. Furthermore, the data would also have to be used to assign a proportion of cause, based on probabilities, attributable to different factors that could cause the disease. There are many examples, especially for cancers, where not all cases can be ascribed to the causal agents identified and being considered in the calculations

- to make the determination, extensive knowledge would be needed of a worker's lifestyle and the environmental risk factors to which the worker has been exposed. This could be an invasion of privacy and would be difficult to ascertain. As the proportion of compensation would depend on this information, there would be an incentive for not providing it. Whether or not the information was provided would be a source of dispute, and this would increase the adversarial nature of the process even more
- such a technique of assigning cause is based on a great deal of judgement, and would need particular expertise. Recognizing that, in practice, the apportionment would be in quartiles or some other fairly large grouping, there would still be dispute over the decision to give 25 per cent or 50 per cent
- it would increase administrative problems in many ways. Although many adjudicators would appreciate the option of something other than 'all or nothing'
- many workers would receive low levels of benefits, which would not, in many cases be sufficient to support them, and might preclude them from other benefits
- can vocational rehabilitation be prorated?
- in many cases the data are insufficient to assign proportions to various risk factors.

It should be noted that reducing benefits was not considered as an option since the task force was considering mechanisms for funding the system for compensating workers for occupational diseases. The task force notes that the Act sets out the scheme of benefits and means of determining them, and that these should be the same for workers disabled as a result of a work-related disease as they are for those disabled by a work-related injury. The unique problems posed by industrial disease cannot be dealt with by reducing benefits. The problems are with determining work-relatedness, and levels of work-relatedness sufficient to qualify for benefits.

5. Universal compensation or comprehensive disability insurance

There are countless possibilities of what such a system would include and how it would be funded. Philosophically, a scheme of universal compensation is very appealing as a means of dealing with the problem of compensating work-related diseases. However, practically it raises many questions.

As it was beyond the task force's mandate, there were no detailed investigations of such schemes or analyses of the experiences of other jurisdictions. However, having considered the problems and having had many respondents to the questionnaire advocate such a system as a means of 'solving the problems', the task force offers these thoughts.

Advantages:

- it would avoid the problems of determining 'work- relatedness'
- all workers with disabilities would be equally eligible for benefits, regardless of occupational status and regardless of cause
- it would reduce administrative costs, costs of appeals and the waste in determining which of the various other systems apply. It would avoid overlap between all the schemes
- it would avoid people 'falling through the cracks'
- it would reduce the adversarial conflicts both in the workplace and between workers and the various authorities
- it would ease the burden on physicians. They would no longer be 'gatekeepers' to the system, especially when it can mean a great deal of financial difference to people
- there should be no delays in the system. This would allow for early intervention for treatment, rehabilitation and remedial action as well as reduce the stress, uncertainty and financial hardship awaiting decisions.

Disadvantages:

- such a system would be very expensive. Assuming that the present level of benefits available under the Workers' Compensation Act will be available to all, the amount of money needed to fund the system will be increased, even considering the savings from amalgamating present systems, and the considerable savings in administration
- to be most effective the scheme would need to be co-ordinated with national and private schemes already in place. Ideally, it would be a national scheme, and therefore require major changes as well as federal-provincial negotiations and agreements for implementation
- reducing the emphasis on whether or not disabilities are work related and changing the system of funding may reduce the incentive to identify causes of diseases and disability as well as decrease the emphasis on prevention. The workers' compensation system, although 'no fault' is thought to provide incentives for employers to run healthy, safe workplaces. The incentives include experience ratings, provisions for penalty assessments and the assessment-setting procedures.

From the discussions and consultations there was a wealth of advice on how such a system should work and how it should be administered. However, all realized that such a scheme could not be put into place without considerable planning and forethought. There was a strong recommendation from occupational physicians for a public inquiry or royal commission into the means of implementing such a scheme. Many groups

supported this recommendation, but for varying reasons and often with different intentions for such an inquiry. Some employer representatives were strongly opposed to the concept of universal insurance; however, there was limited support for an inquiry into the system of funding on the condition that it not interfere with the present initiatives of the WCB towards cost containment. However, some employer groups opposed the proposal for a royal commission.

Public Inquiry/Royal commission

At the beginning and at the end of the task force process, the members were frustrated at the intractable nature of the problem. The whole system of workers' compensation is dependent on determining that work contributed to, or caused, the injury or illness. The reason that occupational diseases have caused so many problems is that rarely can a causal relationship be 'proven'. This leads to delays, disputes, adversarial relationships and extra costs to the system, often to the detriment of the worker's health, rehabilitation and well-being. Such a situation is against all the fundamental goals of the system.

While there is difficulty determining causation, reliance has to be placed on legal decisions on the balance of probabilities. This is reminiscent of the reason for instituting a WCB system in the first place: to remove it from the courts and arguments about fault. The task force concluded that no amount of tinkering with the present system would make it ideal, i.e. that all workers with illnesses that developed as a result of their work would receive fair and adequate compensation. Some workers will not be compensated for illnesses resulting from their work, and others that may have suffered the illness, even if they had not worked, will receive compensation. While some receive compensation and others do not, there will be disputes. While there are disputes, there will be delays as the adjudicators try hard to make the best possible decision. There will be appeals and incredible costs to the system. Some workers will be 'lucky', others will not.

The only way to prevent these problems would be to compensate all. Would this mean that non-workers should also receive 'compensation' for illnesses and injuries? Who should pay for such a system? It was to answer these and other such questions that many groups that the task force spoke with advocated a royal commission or public inquiry into a system of universal compensation or comprehensive disability insurance system. Although extremely attractive for solving the problems posed by occupational disease compensation, the task force recognized that a system of universal compensation is extremely complex and costly. It goes beyond occupational disease, beyond workers' compensation and beyond the province, to include/affect many federal programs. There was a question about whether such a solution is too drastic for what, at this time, is only a small proportion of workers' compensation claims. Could adjustments to the present system help improve its functioning to compensate more work-related illnesses, to avoid compensating too many illnesses that cannot be shown to be work-related, and to reduce delays, administrative costs and the adversarial nature of the process? As this was the mandate for the task force, this was the course taken. However, it has to be stressed

that as many groups indicated to the task force, such changes cannot address the real problem - the present system of workers' compensation cannot work effectively for occupational diseases when it is often impossible to determine cause.

What is needed

There needs to be a thorough examination of the issues of funding, commencing with those identified in the report. The task force concluded that if the system is still found to be unmanageable after the changes recommended in the report are made, either the whole system has to be changed and new sources of funding found or the Act has to be amended. Such amendments to the Act to change its intent would need thorough public debate and the will of the legislature.

Recommendation

#51 that a committee with members from the affected parties be established to examine in detail the funding options as outlined in this report, and to recommend to the Minister of Labour and the WCB whether any are acceptable, practical and capable of resolving the issues of cost allocation and funding for occupational disease claims.

If the committee (referred to in recommendation #51) cannot recommend a satisfactory solution, serious consideration should be given to establishing a royal commission into the issue of funding the workers' compensation system.

It should be emphasized that the task force, although recognizing minor problems, and some confusion with the Act, considered that the system can work effectively and more efficiently to compensate workers fairly for injuries and illnesses resulting from employment. It is anticipated that if the recommendations contained in the report are implemented as soon as possible, there will be considerable improvements in the effectiveness and efficiency of the present system and a reduction of the time delays, costs and number of appeals.

G. REHABILITATION

Rehabilitation is an important part of worker's compensation. However, the focus of this report has been on the adjudication of industrial/occupational disease claims - the determination of entitlement for benefits under the Act. As noted throughout, the problems faced determining work-relatedness are, in many instances, different and more difficult for diseases than for the classic 'injury by accident'. Two questions asked by the task force were

- Are there aspects of rehabilitation and benefits that are different for occupational disease? and
- Are they being adequately dealt with by the present system?

There is no doubt that both medical and vocational rehabilitation for disease cases are different from those for injuries. The problems are often more complex and difficult to deal with. Nowhere is it more evident that the only way to deal effectively with the issues is prevention. In many ways the issues faced in returning workers to the workplace will require changes to be made at the workplace. Such changes should, not only help prevent recurrence or exacerbation of symptoms, but they should also help prevent other workers becoming ill.

The CCU-D, like the Integrated Service Units, deals with benefits and rehabilitation as well as entitlement. The CCU-D has a vocational rehabilitation specialist and two caseworkers associated with the centralized unit in Toronto, and there are caseworkers across the province. With the recognition of the importance of these functions, the unit is in the process of hiring another case worker and a vocational rehabilitation technical adviser.

Concerns

It appears as though the most commonly encountered issues in rehabilitation for workers with 'industrial diseases' are those associated with asthma and sensitivities. Reinstatement provisions may not be appropriate for these cases. Benefits and future economic loss (FEL) and/or non-economic loss (NEL) provisions are difficult to apply if the worker is not 'impaired' when away from the workplace. However, the recent amendments to the Act have made it somewhat easier, and sensitization can be viewed as impairment of the immune system.

There are also problems with cases of aggravation, such as asthma. These are similar to those for other cases of aggravation, such as soft tissue injuries and cardiovascular disease. One concern is how long should benefits continue when a worker is no longer physically impaired when not in the workplace. Often, such cases are prime candidates for a retraining program. Should there be provisions for such workers to be supported through a two-year training course if the symptoms due to the aggravation will be resolved in six months? The choice of rehabilitation provided for workers, and,

probably, their subsequent ability to return to gainful employment, will depend on the answers to these questions.

Medical rehabilitation has not been actively pursued in most cases of occupational disease. There may be no referrals to medical facilities for early rehabilitation, or such facilities may not be readily available. Areas of particular concern are for cardiac rehabilitation, where facilities may be available, and for respiratory conditions, where opportunities for rehabilitation are less common.

Vocational rehabilitation and effective return to work can be hampered if the worker is not receiving adequate medical rehabilitation. In certain cases there may be a lack of knowledge, by both the worker and the rehabilitation caseworkers, of the capacity and limitations of the workers' condition and potential for relapse, recurrence or aggravation. There was also concern at the lack of regionalized vocational rehabilitation and co-ordination with medical rehabilitation.

Analysis

Many of the issues surrounding rehabilitation and benefits for diseases are similar to those for injuries. The issues posed by sensitizations are different. Often, for terminal illnesses or chronic respiratory conditions, the latent period of the disease or delayed onset means that workers have retired or are nearing retirement. In these cases the issues are not so much rehabilitation and FEL assessments, but NEL. The level of NEL is determined within ranges specified in the American Medical Associations guide.

Rehabilitation is particularly important in cases of sensitivities and conditions that require a worker to be removed from a workplace or from exposure to a substance because the condition may be a precursor of an industrial disease. In these cases there has to be a 'liberal' interpretation of 'is thereby impaired ...by an industrial disease'. It is the task force's understanding that, at present, if a worker is removed from a workplace, the worker is considered to be disabled from earning full wages. For instance, if there is evidence that a worker has a raised level of exposure to a substance, and there is the danger that further exposure could lead to adverse health effects, there may be the requirement under the Occupational Health and Safety Act to remove the worker from exposure. This is the case for lead exposure under the Designated Substance Regulations. Such workers may not be impaired or suffer a 'medical condition'. These removals may need to be temporary or permanent, and the workers are prime candidates for rehabilitation.

For such cases, there has to be consideration of the type of workplace, the substances and levels of exposures possible, the types of sensitivities, whether there are any medical restrictions, and, therefore, whether reinstatement is appropriate. What are the employer's responsibilities in these cases? When considering the types of retraining, there has to be careful consideration of the types of substances likely to be encountered.

Other considerations are whether the sensitivities are likely to extend beyond the inducing agent and whether the accumulation of a substance will gradually decrease to a point that a worker could again work in low-level exposure without the risk of adverse health effects in the future. Unfortunately, with the present state of medical science, this cannot always be accurately assessed. For example, even when blood lead levels drop, it is not clear whether the buildup of lead in the bones and other tissues in the body will still pose a risk of adverse health effects.

Rehabilitation is an important component of worker's compensation from the perspective of the worker's health and well-being and the return of the worker to gainful employment as well as for reducing the costs to the compensation system. There are a number of examples of workers being able to return to work in other areas following rehabilitation, with considerable cost savings to the WCB. Nowhere is this more obvious than in the case of sensitivities. Workers, when not exposed to the sensitizing agents, may be fully functional with no residual impairment or disability. If the workplace caused the sensitization, then the worker is entitled to benefits while removed from employment. Sensitivities can, and usually do, affect young workers; therefore, suitable medical rehabilitation (if available), retraining and re-employment are of particular importance and can save the system a considerable amount of money. The Report of the Chairman's Task Force on Service Delivery and Vocational Rehabilitation contains a recent analysis of vocational rehabilitationand its importance, and a focus on the service delivery aspects. It includes a number of recommendations. Although the difficulties were acknowledged, there was no discussion of industrial diseases. The task force agreed with many of the general points and the principal of service excellence.

> Injured workers and employers must receive consistent service reflected in sound decision-making and case management that is clearly understood by all parties and delivered within reasonable time lines.

What is needed

Medical rehabilitation of workers with occupational diseases should be reviewed. There should be more emphasis on early intervention and treatment. In cases considered to be irreversible there should be efforts to prevent diseases from progressing and/or relapsing. Workers should be fully informed of all the medical rehabilitation options available, and appropriate referrals should be made.

The program of vocational rehabilitation for disease cases should be aggressively pursued. The program should be closely co-ordinated with medical rehabilitation. There are advantages to having these functions located with the entitlement adjudication for diseases because of the special considerations for diseases. The information on file and workplace inspections should all be harmonized and shared. However, it is also important to have medical and vocational rehabilitation available locally for workers. A great deal of importance should be placed on the conditions of the workplace, exposures

and the types of work available. This should be emphasized not only for reinstatement, but also as a means of prevention. The different considerations for reinstatement of workers with industrial diseases should be clearly identified.

Consideration should be given to a special fund, like the SIEF, to offer employers an incentive to employ workers who have sensitivities. However, there should be careful screening of workplaces to determine the substances/agents present or used and the 'housekeeping' precautions in place. There should be medical follow-up on re-employed workers to detect any early signs of recurrence or extension of the sensitivity. This is especially important for workers who have been removed from exposure to a substance because their condition may be a precursor of an industrial disease.

There should be an active campaign to educate workers, employers and physicians about sensitivities, to allow early detection and prevention of exposures. It would also alert examining physicians to the importance of distinguishing between conditions that are aggravated by workplace exposures such as bronchitis of viral or bacterial origin and bronchitis which is an allergic response to a workplace chemical. The former will only require removal of a worker until the symptoms are resolved, whereas the later may require removal from the sensitizing or causative agent for the rest of the worker's life.

Summary and Recommendations on Rehabilitation

- rehabilitation is an important part of the system, from both the worker's and the employer's perspective. It is important in preventing adverse health effects by removing workers from conditions that are hazardous and returning workers to gainful employment and quality of life. It can also save the system a great deal of money in long-term benefits.
- sensitivities and asthmas pose different challenges to the system, which need to be specifically addressed.

#52 that there be an active campaign by the WCB to educate workers, employers, physicians, occupational nurses, hygienists and other health care workers about sensitivities, to allow for early detection and prevention, and to alert physicians to the importance of distinguishing between sensitivities and aggravation of symptoms.

#53 that the WCB devote more resources and attention to rehabilitation of occupational disease claimants.

#54 that medical rehabilitation strategies for workers with occupational diseases be reviewed and every effort be made to co-ordinate medical and vocational rehabilitation.

G. OTHER ISSUES

In this section there is a brief discussion of other issues brought to the task force's attention. In many cases these were not directly part of the process of adjudication of occupational disease claims, but influenced it or were influenced by it.

Some of the general concerns and questions asked are listed below.

- Application of the provisions of the Act to sensitizations when a worker is not 'impaired' unless in the presence of particular substance(s)/agent(s). For a worker with a sensitization, the earning capacity or ability to work may differ from other workers with sensitizations, and from those with other disablements. In many cases these differences will not be assessed. Different factors need to be taken into consideration: for instance, the types of substances that the worker will be exposed to in the workplace, whether the sensitization is specific or whether it has developed to include many other substances, or has potentiated sensitization to a variety of factors including environmental agents. Also, a worker may need to be removed from the workplace, sometimes two or three times for varying lengths of time, in order that the condition may be diagnosed. Therefore, even if the worker is not shown to have a work-related sensitization, there needs to be provision of benefits for the time lost.
- Entitlement for rehabilitation being dependent on demonstration of disability. This is considered to be counter to the preferred approach of early intervention and initiation of strategies to prevent the condition/disease progressing to the point of it becoming a disablement.
- Is it realistic to expect workers to return to work once their condition has been diagnosed as a terminal disease? What about the case of diseases that cause a degree of impairment but still allow the worker to work, like chronic obstructive lung disease?
- The ability to prorate permanent disability pensions was lost with the recent amendments to the Act (Bill 62). Although this prorating was only for certain lung diseases, there was the limited ability to account for some lifestyle risk as well as some occupational risk, as in the development of chronic obstructive lung disease.
- In some cases the requirement to complete the assessment for FEL and vocational rehabilitation within the 12 months allocated for temporary benefits is unrealistic. Primary adjudication of disease claims can take six months or longer.
- What forms of benefits and rehabilitation are available for workers removed from the workplace due to diagnosis of a precursor condition?
- The application of the FEL provisions. There is a question of whether the provision is adequate for dealing with the slowly progressive nature of some illnesses.
- The role of the appeal system in the adjudication of occupational disease claims.

The task force did not attempt to resolve these questions and issues. However, it anticipates that if the changes recommended are implemented, and if adjudicators have direct access to the appropriate technical expertise, many of these issues will be resolved, or at least made easier to deal with. For instance, if there is consideration of the specific needs of occupational disease and delayed onset conditions at the time that policies are developed, the questions surrounding the application of such provisions as NEL and FEL will be addressed. If not, the role of the technical expertise designated to support the CCU-D would be to immediately analyze the implications for diseases, and draw up guidelines to aid adjudicators deal with the issues. Similarly, as the issues arise with adjudicators, the need will be identified and have priority for action: firstly at the departmental level through the technical support, then at the policy level.

There was a brief discussion, in the section on policy formation,of the appeals system and its role in setting precedents.

The issue of rehabilitation and the special problems posed by cases of sensitivities and cases of aggravation was briefly discussed above.

Regionalization

An issue raised in some of the communications with affected parties was whether or not the adjudication of occupational diseases should be regionalized.

Present Situation

As noted in the adjudication section, all disease claims, with the exception of noise-induced hearing loss and some of the dermatitis claims, are sent to the Complex Case Unit - Diseases (CCU-D) for adjudication.

Concerns

The majority of the concerns on this issue were from the injured workers who felt that they were better served by having adjudicators who were closer, more accessible and, therefore, more likely to understand the conditions of the work and the regional issues. Employers also expressed concern at the remoteness of the adjudication.

Analysis

The task force recognized the advantages of regionalized adjudication. These include having adjudicators accessible to workers and employers where there is an understanding of local concerns and the ease of interacting with local doctors. This should lead to a better understanding of the limitations of the information sought, both from medical specialists and of workplace conditions. There are also significant advantages in having medical and vocational rehabilitation services at a regional level. However, as occupational disease claims are inherently more complex than most injury claims, and as they represent a small percentage of the total number of claims, there are advantages to having a centralized, specialized unit.

The advantages of a specialized unit include

- adjudicators have greater expertise and experience in dealing with the different types of issues. If there is a heavy case load, the difficult cases tend to be left to one side, while the 'easy' and 'quick' cases are dealt with in an expeditious fashion
- specialized adjudicators know and understand the different types of information that need to be gathered, and are more familiar with the more difficult process of 'weighing the evidence'
- greater time can be devoted to each claim to ensure that the investigation is thorough and that all the relevant information is sought and considered. This should reduce the likelihood of appeals and, often, extensive reinvestigation by worker and/or employer advocates as well as by the appeals officer or tribunal
- that technical experts are available and accessible to advise adjudicators. Communications are facilitated when advisers and adjudicators are physically located together. An excellent example of the value of communication is the

weekly 'case rounds', where the occupational medical consultants discuss cases of interest, to get input from their colleagues on the difficult, interesting or different cases with which they are dealing. The educational value of these sessions should be promoted, and extended to include other members of the specialized unit

- there can be better communication between the adjudicators and the technical experts in all fields, including those responsible for translating policies into guidelines, so that there can be clarification and discussion of problematic cases
- that consistency in decision making will be enhanced when, 1) there are fewer adjudicators making the decisions, and 2) there is good communication between adjudicators and between adjudicators and technical advisers
- comprehensive and consistent data collection can be facilitated.

The task force recognized that a number of these advantages could be maintained even if services were regionalized. Communications between regions is facilitated by a variety of electronic technologies.

What is needed

Although the task force is not recommending regionalization of the adjudication of occupational disease claims, it does consider that there should be serious investigation of ways to regionalize the service in the long term. The task force believes that, as better policies and guidelines are developed, adjudication will be simplified and expedited for many claims. When this stage is reached, the more 'routine' cases should be dealt with in the regional offices. It is likely that there will always be a need for a 'complex case unit - diseases' to be a referral for truly complex cases and a source of expertise for regional adjudicators. If such a system evolves, it may be found that areas of expertise develop in regional centres where the diseases are most prevalent. For example, expertise on diseases affecting miners will develop in the northern regions, expertise in respiratory conditions affecting farmers may be centred in areas of south western Ontario, etc.

The task force considered that whether or not the services are regionalized, there must be

- accessibility of adjudicators to workers and employers
- emphasis on thorough investigation of the local conditions
- communication. Communication between adjudicators with similar cases, with technical advisers and examining physicians.
- close co-ordination of the efforts with medical and vocational rehabilitation. A lot of the information gathered by the adjudicators is essential to optimize rehabilitation, reduce duplication and ensure early intervention.

IV CONCLUSION

The task force examined the principles underlying the approach of the WCB to the adjudication of occupational and industrial disease claims. It did so by investigating the way disease claims are adjudicated and the guidance that is offered for the process. This led to the identification of a number of problems and an examination of the whole process, including identification of diseases, policy development, adjudication and, to a lesser extent, funding and rehabilitation.

The task force soon realized that many of the problems and concerns with the present system are inherent in the nature of occupational disease rather than the system or adjudication process. The primary difficulty is that for many diseases, the causative factors cannot be determined with any certainty in a particular individual. As the entire workers' compensation system depends on determining whether or not the disease in a particular worker was caused by work, for most diseases it is scientifically or medically unrealistic. Also, as medical and scientific understanding of disease causation increases, it is clear that employment (work, factors and exposures at work) is involved, to a greater or lesser degree, in the development and or manifestation of most diseases.

Recognizing that employment can affect the development of many diseases traditionally considered diseases of normal life, like cancer and heart disease, poses the critical dilemma: How many of these diseases can or should be compensated for as occupational diseases through the workers' compensation system?

The task force first investigated the legislation and case law to determine the test for entitlement. It concluded that entitlement for benefits under the Workers' Compensation Act depends on the demonstration that, **on the balance of probabilities, work made a significant contribution to the development of the disease, and when the evidence for and against are considered equal, the benefit of the doubt should be given to the worker.** This is a legal test, and the underlying principle for adjudication.

Recognizing that determination of causation involves complicated interpretations and extrapolations of scientific data that, in many cases, are not available, weak or inconclusive, means that determining whether employment made a significant contribution to the development of a disease cannot be made based on science alone. Similarly, it would be difficult to establish that employment did not make a significant contribution to the disease.

There was debate about what 'significant contribution' means. It is the legal test that is based on weighing evidence, and it must be recognized that judgement has to be exercised. It is considered to be more than 'any' or de minimus contribution and less than 'sole cause'.

Having considered the specific issue of occupational disease adjudication within the present system, the task force identified a number of key issues.

- The Act defines entitlement for workers' compensation.
- Entitlement is a legal decision about whether, on the balance of probabilities, work makes a significant contribution to the development of an impairment or disability.
- Adjudicators act for the Board of Directors in making entitlement decisions.
- The rest of the components of the workers' compensation system should be designed around the fundamental goal of helping adjudicators make fair, timely decisions, consistent with the Act, and based on the best information available.
- Schedules, policies and guidelines are key to providing adjudicators with the best information available.
- Rather than a clear distinction between injury and disease there is a continuum of medical conditions that reflects different mechanisms of action and other characteristics of the 'injuring process'.
- Distinctions are only necessary, or useful, to make allowance for different means of determining a causal relationship and to provide fairer mechanisms for allocation of costs of claims.
- Because of the complex etiology of diseases, the gaps, the limitations, and the ever-changing scientific information available and the difficulty of identifying causal relationships, there need to be
  - principles enunciated to guide the interpretation of the Act
  - mechanisms to structure decision making. These range from schedules with presumptions to general guidelines on the type of information to be considered in decision making. The different tools provide varying degrees of flexibility to adjudicators depending on the certainty (strength of the evidence) about the causal relationship
  - guidance and technical support for adjudicators.
- Policy decisions are the ultimate responsibility of the Board of Directors of the WCB. They need to be made based on the best information available, but considering all the information, and the implications. As they are public policy decisions, they should involve the affected parties in an open process.

Research aimed at identifying occupational disease is peripheral to the issues of adjudication, but necessary to help provide information towards elucidating causal relationships. The system for occupational health and compensation research in Ontario needs considerable improvement to reduce duplication, determine priorities, focus the research, rationalize costs, ensure high quality and thorough peer review and to ensure that the studies will be useful and used in policy development. The task force concluded that the research needed for both occupational health and compensation is the same, and that efforts and resources should be co-ordinated and centralized. It is recognized that once the research has been interpreted, the information will be used differently by the two disciplines. **The task force emphasizes the importance of research being aimed**

at prevention, because, ultimately, prevention is the only effective means of dealing with compensation issues.

Although the task force's focus was adjudication, it recognized that one of the main sources of controversy, not only in Ontario but in many jurisdictions, is the cost of the system. Concern over costs is leading to a questioning of the system's ability to cope with diseases and other medical conditions where there is a clear overlap between work and non-work factors. The questions include:

- Is it fair for employers to have to pay the costs for diseases that may have a high probability of occurring without a contribution by work factors?
- Is it fair that workers with such conditions who work where there is an increased risk, not get compensation and bear the total cost of the income loss and the pain and suffering?
- Who should pay the cost?
- What is the cost? Should it be measured in lost income or in costs to workers and society in general?
- Should the determinant of whether a worker receives benefits be
    - a legal test: a judgement call on the contribution work made to the development of the disease, recognizing the limitations of the science and the assessment of work (exposures)?
    - whether the present workers' compensation system can 'afford' to pay?

The task force analysed the various components of the system focusing on how they support the process of adjudication. It makes a number of recommendations that it believes will help the system function more effectively, more efficiently and in a fair manner. It recognizes that until the issue of how the system can be funded so that the costs of occupational diseases are fairly allocated, the controversy will not be resolved, and the pressures on the system for change will not abate. However, the task force considered it important to note that the cost of the system and the present debt are <u>not</u> due to problems funding occupational disease claims, which are only a small fraction of the total claims to the Ontario WCB. Therefore, if an entirely new system of workers' compensation is sought, it should not be justified solely on the basis of the difficulties adjudicating and funding occupational disease claims.

It was not within the task force's mandate to redesign the system or determine mechanisms for funding; however, it offers its thoughts on a number of alternatives to the present system.

Proposed Implementation Plan

The task force was appointed by order in Council to perform a review of compensation for occupational and industrial disease under the Ontario Worker's Compensation Act and to make recommendations for change. It conducted a thorough review of the system, consulted widely and, from its analysis, proposed strategies for improving the system. The task force took the unprecedented step of presenting its proposed recommendations to focus groups and encouraging open discussion of the proposals.

This report represents the consensus reached following consideration of the analysis of the present system and all the input and discussions.

There are a number of recommendations for change, which the task force considers essential to improve the system. It is also aware that a number of initiatives have been pending, awaiting this report. Therefore, the task force strongly urges the minister to take immediate steps to ensure that the recommendations are implemented without further delay.

Many of the changes are relatively easy to implement, and the process could commence immediately.

- The Board of Directors should
  - ensure that the purpose and intent of the Act are publicized
  - in consultation with the IDSP, immediately develop guiding principles, including those identified in the document.

- The steering committee for the research centre should be formed to commence making arrangements to establish both the research centre and the advisory committee to achieve the objectives laid out in this report.

- Structural and functional changes to the IDSP should be implemented. These are not prevented by the existing legislation therefore, although the Act will need to be amended to clarify theses issues, implementation can commence immediately.

- The organizational changes within the WCB should be implemented immediately so that the adjudicators are provided with the technical assistance, resources, training, 'tools'(guidance outlined in the report) and recognition that they need and deserve.

- The committee to advise on collection and collation of data be established.

- The committee to review the funding options outlined in the report be established by the Minister of Labour immediately.

The task force suggests that to facilitate the implementation, the Minister of Labour appoint an implementation committee composed of a member from each of the agencies affected by the recommendations. The members would then be responsible for facilitating the changes within their agency and reporting to the minister.

The minister of Labour should ensure that the above occur and he should commence the process for amending the Workers' Compensation Act to

- clarify the definition and presumptions associated with compensable medical conditions
- include the intent in a preamble
- clarify the functions of the IDSP and specify its structure.

Also, the process of amending the Occupational Health and Safety Act should commence to

- establish the research centre, and
- make other changes necessary to clarify the research mandate and avoid duplication.

The Minister of Labour and the WCB should commence the longer-term initiatives involving communication, promotion and education in occupational health, disease prevention, identification and compensation.

The report contains the objectives of the changes recommended, and in many instances details (and gives reasons for) the process and content of the changes. Therefore, the body of the report contains not only the analysis that led the task force to its recommendations but also the information needed to implement the recommendations, i.e. a guide to implementation.

Finally, the task force wishes to thank all those who met with, communicated with and provided information to the task force and research co-ordinator. The task force believes that the only true way to show its appreciation would be if it could ensure that changes occur to improve the system. Many people have put a great deal of time and effort into the process, all with one goal, and the task force hopes that the efforts will be rewarded.

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FIGURE 6	Adjudication Process
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FIGURE 9	Determination of Criteria

FIGURE 1
TASK FORCE PROCESS

1991	PROCESS	INFORMATION SOUGHT	PHASE
SEP.	OIC APPOINTMENT OF MEMBERS & CHAIR		
OCT.	RESEARCH CO-ORDINATOR AND MEDICAL ADVISER APPOINTED		
	MEETINGS WITH ORGANIZATION & AGENCIES		
	LITERATURE REVIEWS	LEGISLATION SYSTEM • STRUCTURE INTERACTIVE COMPONENT • POLICY MAKING • ADJUDICATION PROCESS • APPEALS • DATA COLLECTION PRESENT PRACTICES EXPERIENCES STATISTICS	INFORMATION GATHERING
1992			
MAR.	ROUND TABLE DISCUSSION		
APR.	INTERJURISDICTIONAL . QUESTIONNAIRE . DISCUSSION		
MAY			CONSULTATIONS
JUN.	SURVEY . EMPLOYERS . OCC. PHYSICIANS		
JUL	CASE REVIEWS		ISSUE IDENTIFICATION
AUG.	CONSULTATION MEETINGS . EMPLOYERS . WORKERS		IDENTIFICATION OF ALTERNATIVES
SEP.			
OCT.	ANALYSIS		
NOV	FOCUS GP. MEETINGS		DRAFT RECOMMENDATION FOR DISCUSSION
1993			
JAN	OPEN FORUM		CONSULTATIONS DISCUSSION MODIFICATIONS
FEB			
MAR			PRESENTATION TO MINISTER

FIGURE 2

MAJOR COMPONENTS OF THE WORKERS' COMPENSATION SYSTEM

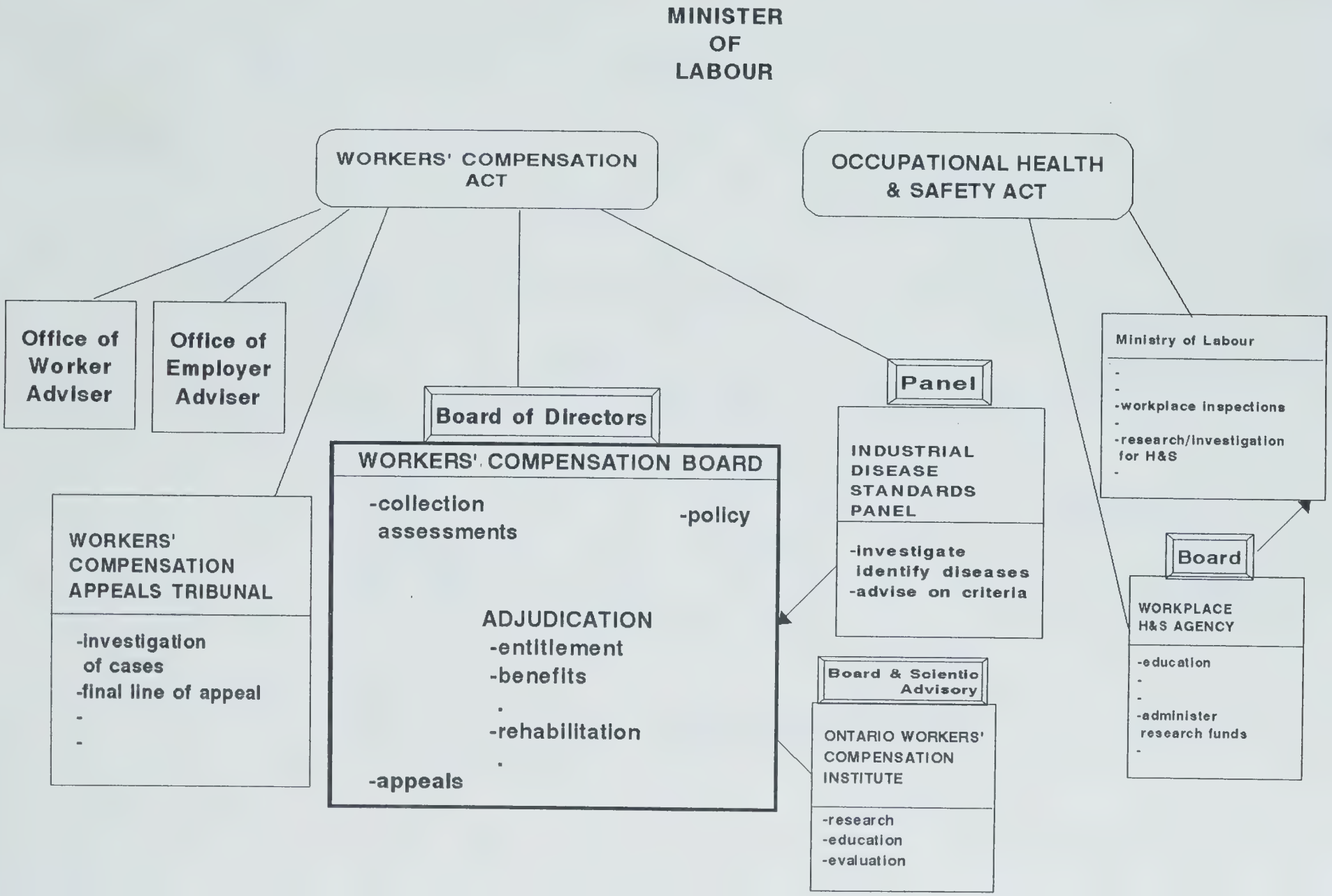
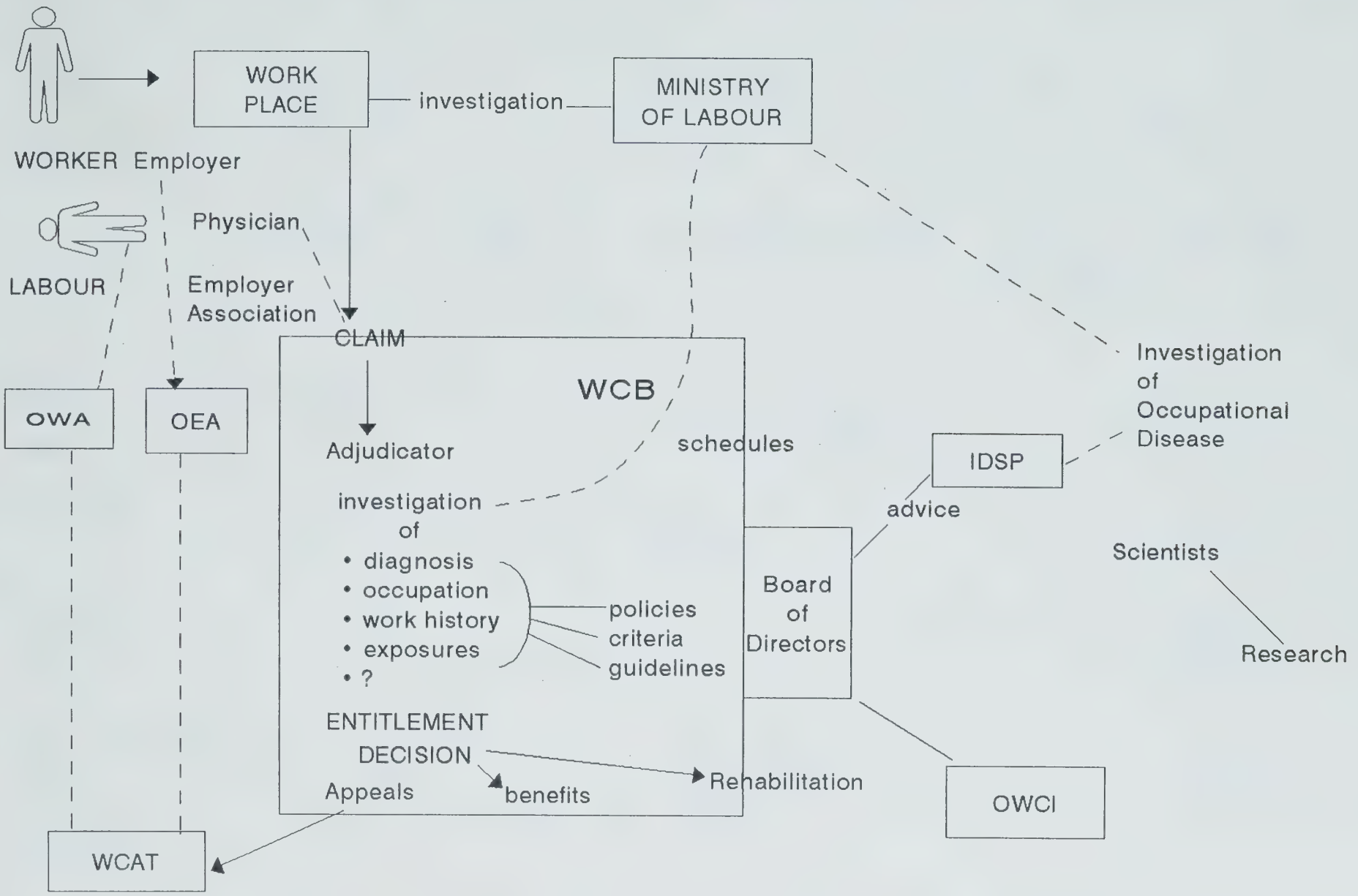
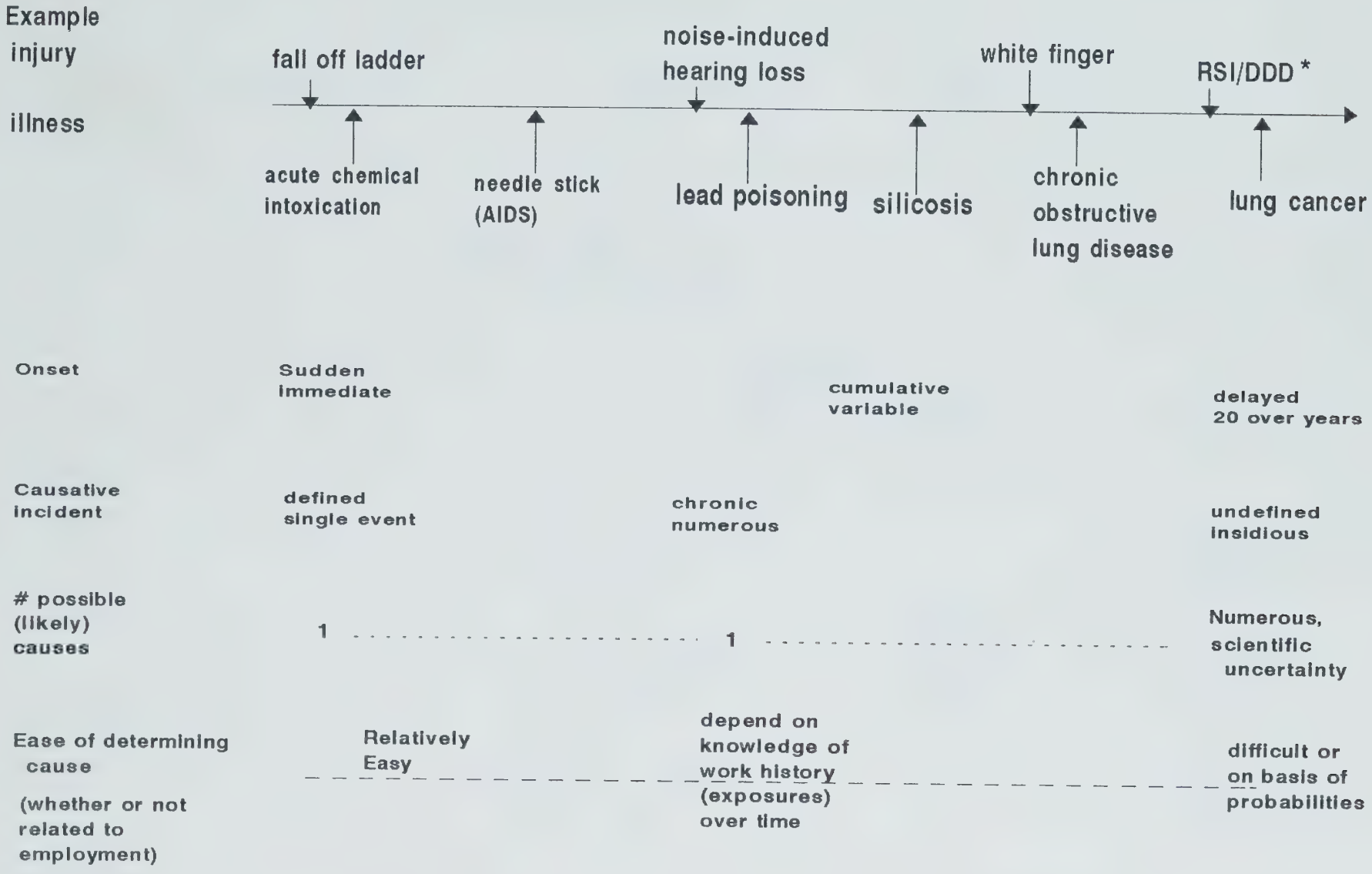


FIGURE 3
OCCUPATIONAL DISEASE COMPENSATION SYSTEM*



* See glossary for abbreviations & acronyms

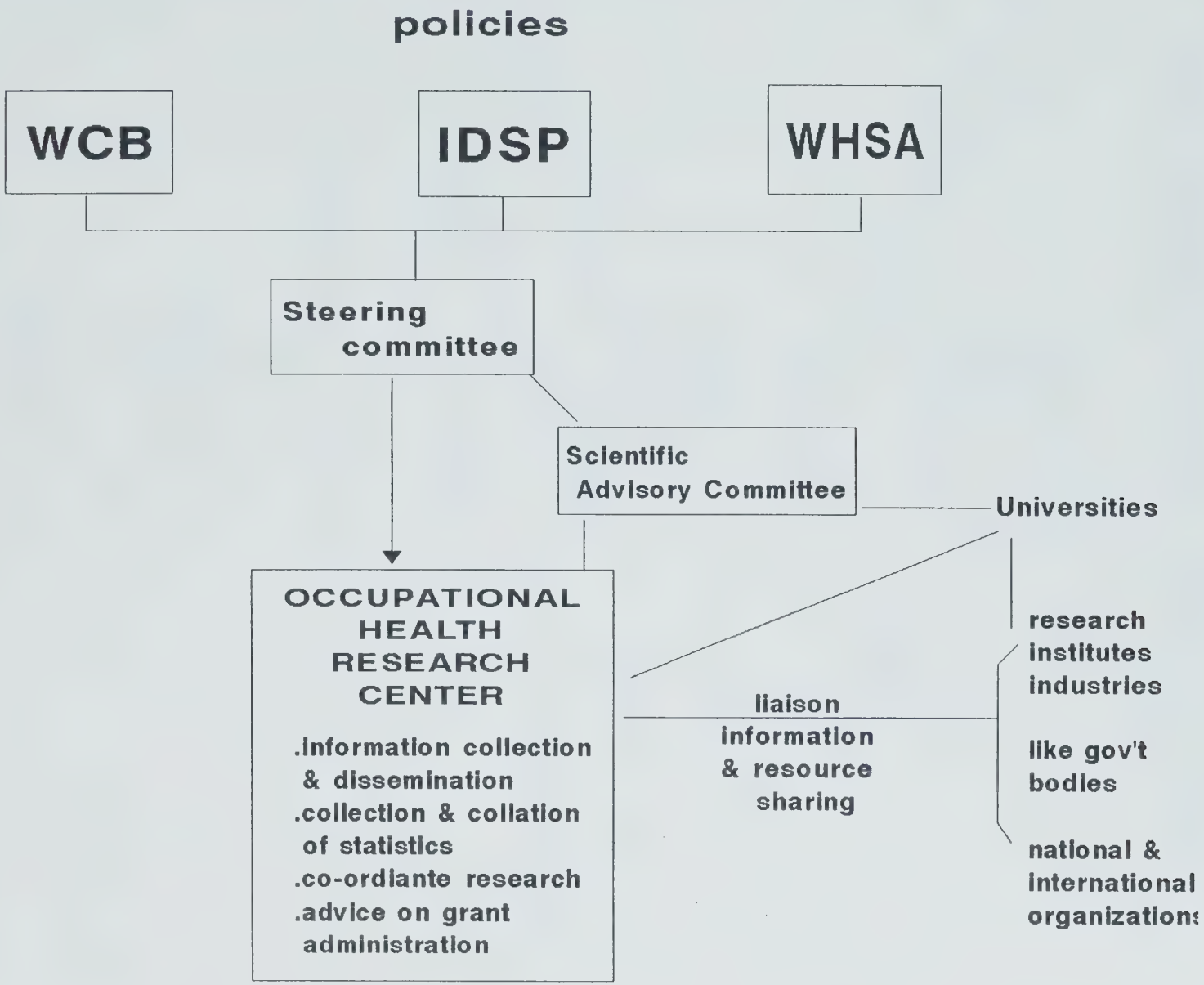
FIGURE 4
CONTINUUM OF INJURIES & ILLNESS



* See glossary for abbreviations & acronyms

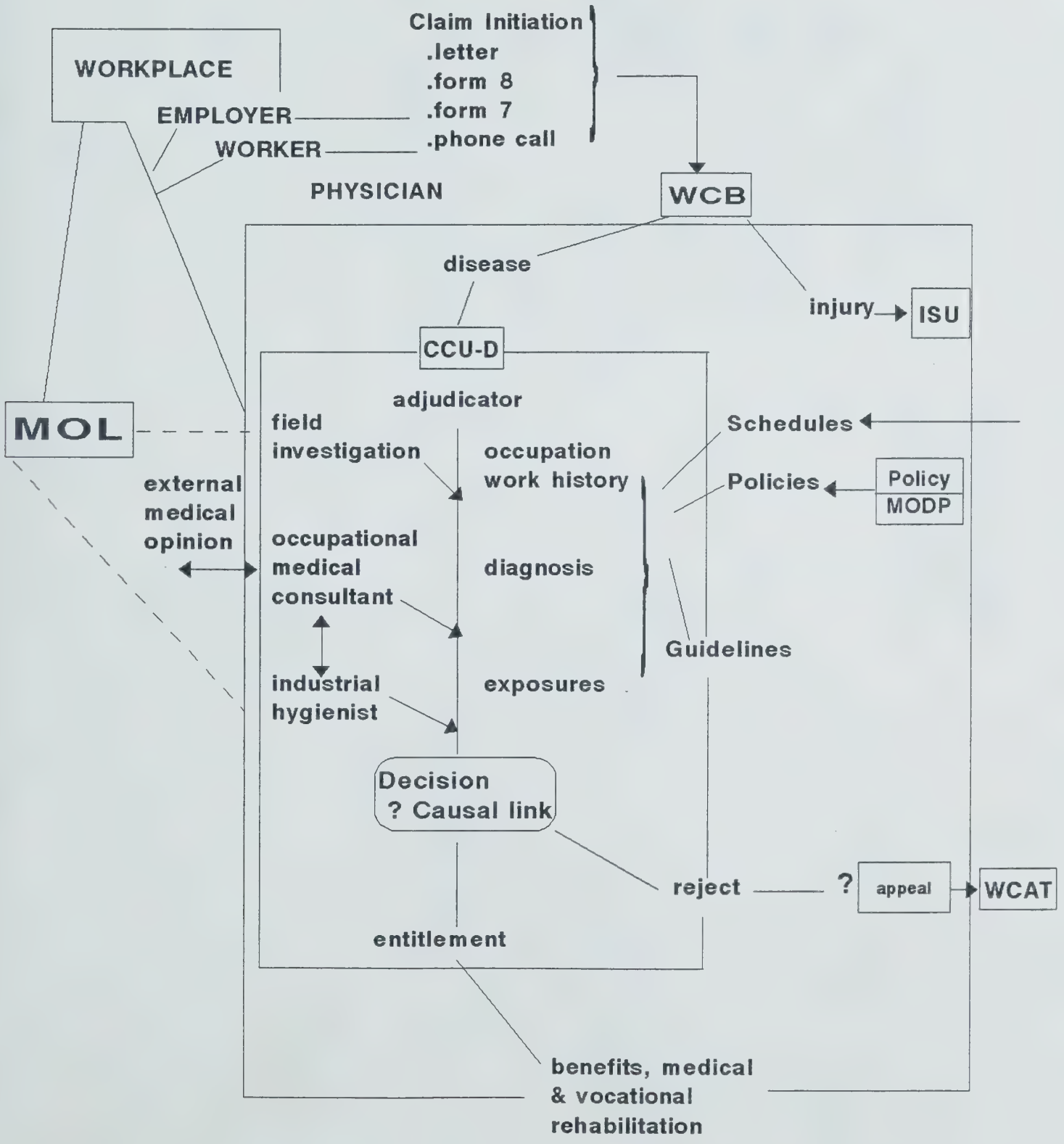
FIGURE 5

PROPOSED SCHEME FOR RESEARCH & POLICY FORMATION*



* See glossary for abbreviations & acronyms

FIGURE 6
ADJUDICATION PROCESS*



* See glossary for abbreviations & acronyms

FIGURE 7
ADJUDICATION DECISION TREE

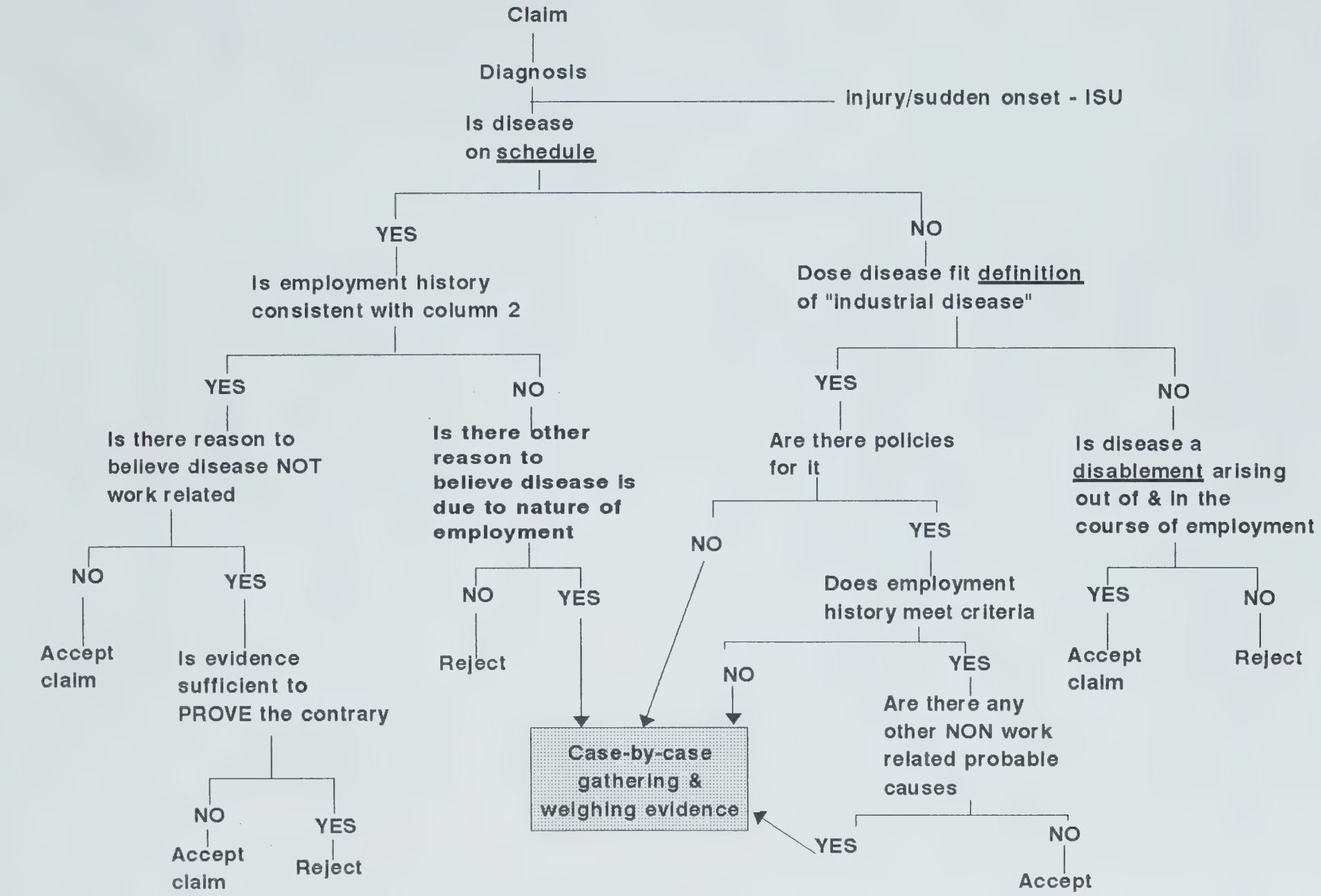
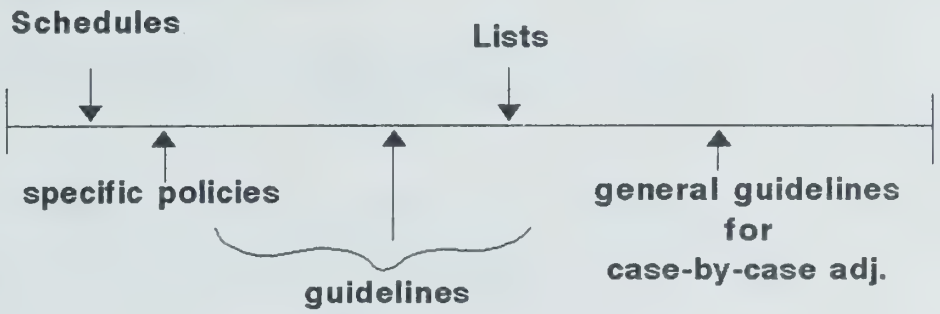


FIGURE 8
CONTINUUM OF TOOLS FOR ADJUDICATION

(MECHANISMS FOR STRUCTURING DECISION MAKING)

TOOLS



Aids

summaries of information (including limitations) about disease/medical conditions which include diagnosis, possible cause & conditions when possible causes are more/less likely

PRESUMPTION

Strong **Weak** **Balance of probabilities**

depends on

DEGREE OF CERTAINTY

about association based on (science)
- **amount of info.**
- **type of info.**
- **power of studies**
  - **significance**
    - **statistical**
    - **biological**
- **strength of association**

strong **Weak**

lot **little**

epi studies + **case reports clusters** **in vitro**

(high) ← **animal studies** **structural analogy**

high **low** **?**

(need to be specified)

Other factors
- **mechanism of action**
- **number of possible causes**

known cause **aggrevation trigger** **unknown**

1 ← **many**

ENDNOTE 1

LEGEND FOR FIGURE 9

Figure 9 is a diagrammatic representation of a dose-response curve. It is used only to illustrate the dilemma of attempting to set 'criteria' or eligibility rules to compensate the 'excess'.

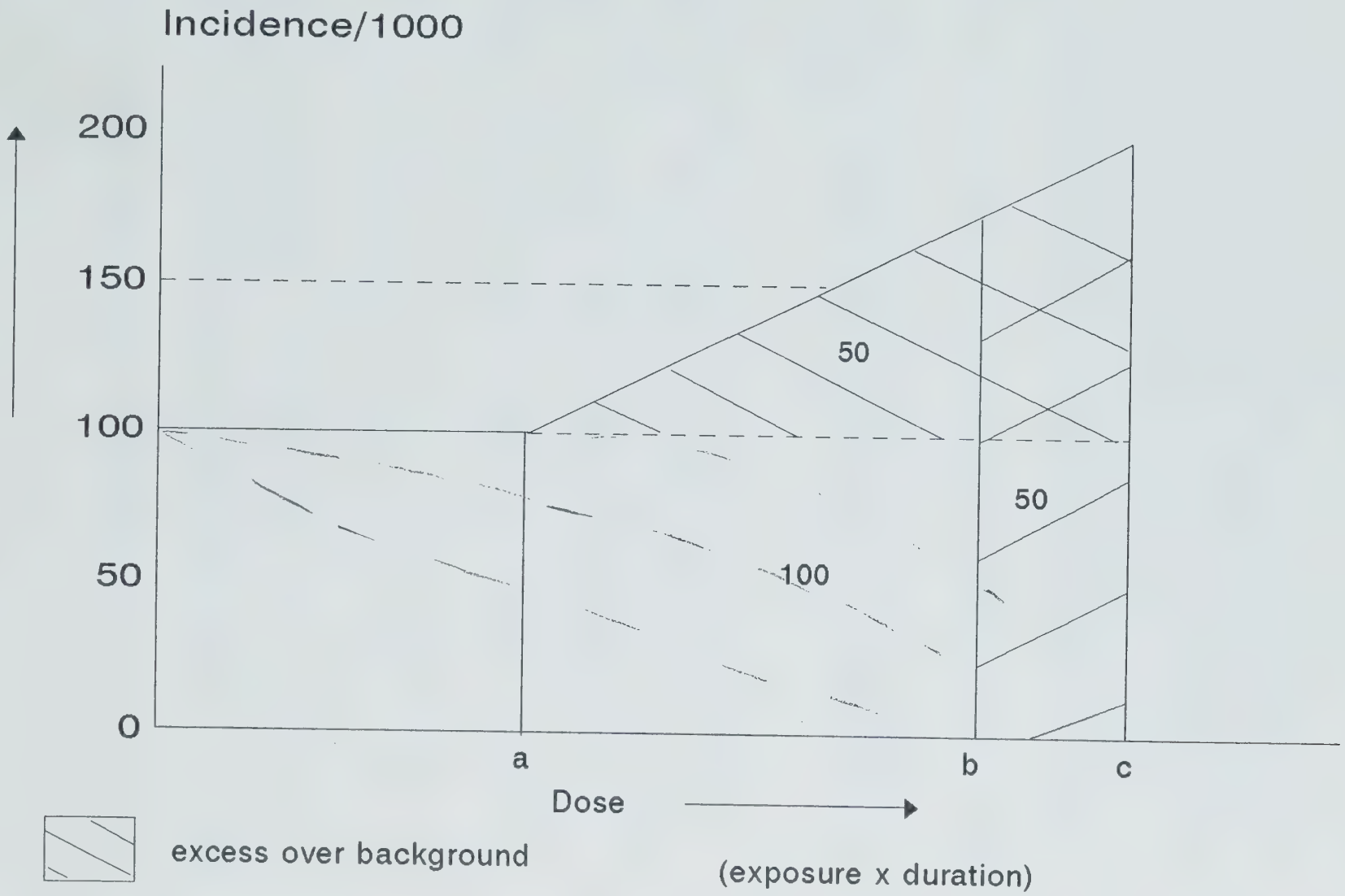
The incidence of disease X in the normal population is 100/1000. If the incidence in workers exposed to substance Y in a particular occupation/workplace is 150/1000, the SMR would be 150. Assuming an idealized dose-response relationship between exposure to Y and the incidence of X, it may look like the curve depicted in Figure 9 if the exposed workers received doses of Y between a and c. This means the increase in incidence (or 'excess' cases) over this range was 50/1000. If criteria or eligibility rules are based on exposure data and selected so that only the excess will be compensated, they would be set at b. The reasoning would be that, between exposures a to c, two out of three workers that get disease X would have got it even without exposure to Y in the workplace (incidence in the normal population). Therefore, the workers with higher exposures have a greater chance that their disease was due to Y, and they should be compensated. The level chosen, b, would be where the area under the curve b to c would be one third of the total area under the curve a to c. As can be seen from the diagram, this means that the chances are that more than half the workers compensated would have developed the disease without exposure to Y and that at least half of those that developed it as a result of exposure to Y would be excluded.

Obviously, this is a simplified illustration, and it makes the assumption that there is no interaction between the factors causing X in the normal population and exposure to Y. In most diseases the nature of actions and interactions is not sufficiently understood to determine how a dotted line should be drawn on the diagram (the probability of Y contributing to the development of X).

This diagram can also be used to illustrates a number of other points

- if 'exposed' had included a wider range of exposures, some below a, the total incidence would be lower, the SMR would be lower and the data would be less likely to be considered significant.
- if an SMR of 200 is considered to be the 'cut off', either the data would not 'qualify' as demonstrating an association or all the cases in the shaded area would be excluded (not meet the eligibility rules).

FIGURE 9
DETERMINATION OF CRITERIA



ENDNOTE 2

When there is uncertainty associated with science, there is a tendency to quantify the data in terms of probabilities that can then be used as a 'measure' of risk. The numbers then take on a meaning of their own which gives the scientist/translator the sense that the calculations can be translated into accurate assessments of the proportion of disease that is caused by a certain factor. These calculations underrate the uncertainty and give the impression that conclusions about individuals can be drawn. This also gives the impression that the decision about causation can be based on science and medical opinion and that it therefore overrides the role of social considerations in the decision-making process. The cause of a disease in an individual can rarely be established with any certainty.

A few selected quotes from elementary or basic epidemiological text books serve as good examples.

'As a scientific discipline matures, a desire develops among scientists in the field to express the phenomena they are studying in mathematical terms. A major appeal is the precision in mathematical symbols that can rarely be achieved in verbal descriptions of biological phenomena'.

'Experimentation and the determination of biological mechanisms provide the most direct evidence of a causal relationship between a factor and a disease. Epidemiologic studies usually provide very strong support for hypothesis of either a causal or indirect association. However, inferences from such studies are not made in isolation; they must take into account all relevant biological information. Epidemiologic and other evidence can accumulate to the point where a causal hypothesis becomes highly probable. Unfortunately, it is not yet possible to quantitate the degree of probability achieved by all the evidence for a specific hypothesis about the cause of a disease, so an element of subjectivity remains. Nevertheless, a causal hypothesis can be sufficiently probable to provide a reasonable bases for preventive and public health action.'[1]

Evans has developed a unified concept of causation that parallels the Henle-Koch postulates and is generally applicable to both infectious and noninfectious diseases.

1. Prevalence of the disease should be significantly higher in those exposed
2. Exposure to the hypothesized cause should be more frequent among those with the disease than in controls
3. Incidence of the disease should be significantly higher in those exposed to the cause than in those not so exposed as shown by prospective studies.

---

[1] Lilienfeld, A.M. and D.E. Lilienfeld. Foundations of Epidemiology. 2nd Ed. Oxford University Press, Oxford. 1980.

4. Temporally, the disease should follow exposure to the hypothesised causative agent with a distribution of incubation periods on a log-normal shaped curve.
5. A spectrum of host responses should follow exposure to the hypothesized agent along a logical biological gradient from mild to severe.
6. A measurable host response following exposure
7. Experimental reproduction of the disease
8. Elimination of the hypothesized causative factor should decrease the incidence of the disease
9. Prevention of exposure should decrease or eliminate the disease
10. All of the relationships and findings should make biologic and epidemiologic and epidemiologic sense.

'Epidemiologists agree that causation has been established when good quality studies demonstrate relationships between exposure and disease which are consistently observed, when disease is strongly related to previous exposure in a dose-dependent fashion and when association make biologic and epidemiologic sense. Criteria have not however been agreed to determine the degree of consistency between different studies, the strength of dose-response relationship or the degree of understanding of the biologic mechanisms which must exist before causation is considered to be proven.'

GLOSSARY

CAALL	Canadian Association of Administrators of Labour Legislation
CCU-D	Complex Case Unit - Diseases (centralized unit of the WCB where occupational disease claims are adjudicated)
DDD	Degenerative Disc Disease
FEL	Future Economic Loss (type of benefit awarded by the WCB)
IDSP	Industrial Disease Standards Panel
ILO	International Labour Organization
ISU	Integrated Service Units (regionalized units of the WCB where injury claims are adjudicated)
IRRST	Insitut de Recherché en Santé et en Sécurité du Travail (Research institute in Quebec)
MODP	Medical and Occupational Disease Policy (Branch of the Strategic Policy Analysis Division of the WCB)
MOL	Ministry of Labour
NEL	Non Economic Loss (type of benefit awarded by WCB)
NEER	New Experimental Experience Rating (System of determining employer assessments at the WCB)
NIOSH	National Institute of Occupational Health & Safety (USA)
NIHL	Noise Induced Hearing Loss

ODISS	Occupational Disease Information Surveillance System (data base for occupational disease claims submitted to the WCB)
OEA	Office of the Employer Adviser
OECD	Organization of Economic Cooperation and Development
OMC	Occupational Medical Consultant (affiliated with CCU-D of the WCB)
OWA	Office of the Worker Adviser
OWCI	Ontario Workers' Compensation Institute
RCA	Royal Commission on Asbestos
RSI	Repetitive Strain Injury
SIEF	Second Injury Enhancement Fund. A special fund within the accident fund of the WCB for paying the costs of claims for injuries which are considered to be a result of a pre-existing condition.
SMR	Standardized Mortality Ratio (or rate. A measure of the proportional increase in the incidence of mortality in a study population compared to a control polpulation. The figure is derived from epidemiological studies)
TLV	Threshold Limit Values (exposure limits developed by the American College of Government Industrial Hygienists. They are used as measures of hazardous substances which are generally considered 'safe' for the average healthy worker exposed 8 hours a day, 5 days a week.)

WCAT	Workers' Compensation Appeals Tribunal
WCB	Workers' Compensation Board
WHO	World Health Organization
WHSA	Workplace Health and Safety Agency (the Agency)

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- Decision 41/91 - 08/02/91. Exposure; bleach fumes - benefit of the doubt.

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APPENDIX 1

Terms of Reference

Occupational Disease Task Force

-TERMS OF REFERENCE-

TITLE:

Review of Compensation for Occupations and Industrial Disease under the Ontario Workers' Compensation Act.

PURPOSE/OBJECTIVES:

General

To examine the principles underlying the approach of the Workers' Compensation Board to the adjudication of occupational and industrial disease claims. To compare Ontario's approach with models used in other jurisdictions. Where appropriate, to recommend improvement in the current model of occupational disease compensation.

Specific Objectives

To examine the statutory framework within which workers' compensation in Ontario addresses occupational and industrial disease claims.

To evaluate the ability of the workers' compensation system (including the WCAT and the IDSP) to identify and respond to occupational and industrial diseases.

To assess and compare the approach to compensation occupational disease in Ontario's workers' compensation system with the methods used in other OECD member nations.

To examine the principle underlying the Board's approach to the adjudication of occupational and industrial disease claims.

To respond to recommendations for change that have been made by commentators and by clients of the workers' compensation system.

BACKGROUND:

The Workers Compensation Act provides for the compensation of designated "industrial diseases" in Schedules III and IV.

An "industrial disease" is defined in the Act as a disease resulting from a particular workplace exposure, or a disease "peculiar to or characteristic of" a process, trade or

occupation. A disease named in Schedule III or IV, or a precursor condition may also be designated by the Act as an industrial disease.

Schedule III provides a statutory presumption in favour of a workers' claim for a list of designated diseases which are believed to be "characteristic of or peculiar to" a corresponding list of occupations. The presumption favouring compensation for an industrial disease named in Schedule 3 can be overturned by the presentation of contrary evidence to show that the etiology of the individual's disease is not related to the workplace.

Schedule IV of the Act currently has no entries, but it permits the Board to recognize a second category of industrial diseases considered to be almost exclusively caused by occupational exposures. Schedule 4 provides a conclusive presumption favouring compensation for a worker who contracts a disease named in it following employment in a listed industry.

Section 122 of the Act sets out the nature of the presumptions of compensation entitlement available to claimants for "industrial diseases" that are recognized by the Act. It also enable the Board to amend the schedules as necessary.

In addition to the specified "industrial diseases" in the schedule, the Board also compensates many occupational diseases are recognized. For example, the Industrial Disease Standards Panel (IDSP) commissions studies of suspected occupational diseases, published its findings and submits them to the WCB to assist in the development of compensation standards.

The independent appeal body (WCAT) also plays a significant role in the recognition of compensation claims for occupational disease through its adjudication of individual appeals and its independent evaluation of Board Policy guidelines.

The incidence of occupational diseases is expected to rise in the 1990's and therefore the ability of workers' compensation to effectively respond to them is significant public policy concern. The Ministry is creating the Occupational Disease Task Force in response to this reality and the concerns shared by the clients of WCB (workers, employers, the medical profession) about the ability f the system to respond to compensation claims for occupational disease. It was decided the topic is too complex to be addressed within the confines of the Green Paper project.

The Task Force Report should also address concerns that have been expressed by employers about the impact of the WCAT decisions upon the Board's current approach to the adjudication of occupational disease cases.

The Task Force will also explore the statutory framework which supports the Board's current approach to adjudicating claims for industrial and occupational diseases. Where necessary, it will recommend changes to the current legislative framework.

MOL officials met with IDSP, OEA, OWA, OFL, ECWC, EAC, and WCB before drafting terms of reference. The IDSP has also been consulted about the study's proposed terms of reference.

ISSUES:

A number of issues have been identified for the Task Force to address:

- Statutory framework governing compensation for industrial and occupational diseases;
- Composition and role of IDSP ;
- Use of Schedules III and IV
- Role of WCB guidelines and administrative policies.
- Eligibility rules and approach to the compensation of occupational disease in other jurisdictions.

PRODUCT:

Two background studies and a report indicating Ontario's ability to compensate occupation and industrial diseases relative to compensation systems in other jurisdictions. It is expected the Report will include:

- an assessment of Ontario's current approach and comparison to other jurisdictions;
- recommendations for change in either the statutory provisions governing compensation for industrial disease, or in the approach taken by the workers' compensation system to recognizing both occupational and industrial disease claim.

APPENDIX 2

Members of Task Force

MEMBERS OF TASK FORCE

Chair	Leigh West, L.L.B., L.L.M. Associate Professor University of Windsor
Employer Member	Roger Rickwood, Ph.D, L.L.M., L.L.B. Director Health, Safety & Environmental Affairs Canada Post Corporation
Labour Member	Andrew King, L.L.B. Staff Representative Health, Safety & Environment United Steel Workers (until Nov., 1992) -WCB Training Co-ordinator, Ontario Federation of Labour (as of Nov. 1992)
Research Co-ordinator	Penny Chan, M.Sc., Ph.D., M.H.Sc. Occupational Disease Task Force
Medical Advisor	David Muir, M.B.B.S., Ph.D., F.R.C.P. F.F.O.M., M.Sc. Occupational Health Program McMaster University

APPENDIX 3

List of Participants and Summary of Round Table Discussion on Compensation of Industrial Diseases (March 4, 1992)

LIST OF PARTICIPANTS FOR THE ROUND TABLE

Occupational Disease Task Force (ODTF)

Leigh West
Chair

Roger Rickwood
Employer Member

Andrew King
Labour Member

Penny Chan
Research Co-ordinator

David Muir
Medical Advisor

Management

David Frame
Executive Vice President
Council Ontario Construction Association
COCA

Ian Howcroft
Employee Relations Policy Advisor
Canadian Manufacturers Association

John Blogg
Manager, Ontario Mining Association
Industrial Relations

Les Liversidge
Liversidge & Associates (for ECWC)

Steve Cryne
Executive Director
Employer Advocacy Council

Agencies

Paul Holyoke
Executive Director
Strategic Policy & Analysis Division
WCB

Lynn Elinson
Director
Medical Occupational Disease
Policy Branch
WCB

Ken Burkimsher
Manager
Complex Case Unit-Diseases
WCB

Niki Carlan
Chair
Industrial Disease Standard's Panel

Ron Ellis
Chair
Workers' Compensation Appeals Tribunal

Ministry of Labour (MOL)

Mitchell Toker
Manager
Workers' Compensation Unit

April Eastman
Policy Advisor
Workers' Compensation Unit

Cherith Muir
Policy Advisor

Labour

Carl Crevar
President
Provincial Network of
Injured Workers Groups

Gary Cwitco
National Representative
Communications Workers of Canada

Linda Jolley
Director of Health & Safety
Ontario Federation of Labour

Mary Morison
Provincial Co-ordinator
Ontario Workers' Health Clinics

John Mckinnon
Injured Workers' Consultants

Others

Sol Sax
Medical Director
Dupont

Michel Gerin
Dept. de Medicine
du Travail
Université de Montréal

Terence Ison
Professor
Osgoode Hall Law School
York University

Katherine Lippel
Université du Québec à Montréal

Ernie Mastromatteo
Consultant

John Oudyk
Ontario Workers' Clinic

Phillip Vachon
McMaster Meighem

Michael Wills
Occupational Health Clinic
for Ontario Workers

Summary notes from the

ROUND TABLE DISCUSSION
on
COMPENSATION OF INDUSTRIAL DISEASES

held March 4, 1992
Chestnut Park Hotel, Toronto

Chair's Remarks

The chair welcomed the participants and briefly described the mandate of the task force. She explained that the purpose for the meeting was to discuss the use and limitations of exposure data in adjudication of industrial disease claims.

She then introduced the members of the task force and asked everyone to identify themselves and give a brief description of their background and interest in the field.

Introductions (see attaced List of Participants)

Presentation on 'Exposure Data' - Michel Gerin

Michel Gerin explained the use and need for exposure data in epidemiological studies, specifically retrospective exposure assessments. He noted that there are two main types of epidemiological studies.

a) Cohort. These involve information on a company or process. Exposure measurements may or may not be available. Such studies do not focus on individuals (but on comparisons of groups).

b) Population-based. In these studies there is little information on employment but there is access to individuals. Most of the information on exposure and employment will be anecdotal and can be obtained through qusetionnaires.

He then described the approach to obtaining information when atttempting to evaluate the the possibility that a worker has been exposed to a particular substance (or a number of substances) in the workplace.

- A questionnaire has been devised with 20 open-ended questions to obtain anecdotal information and work history. Depending on the particular occupation, specialized questions can be added. This information depends on memory and there is opportunity for biases.
- 'Hard data' on exposures through industrial hygiene records, both past and present. Other forms of hard data are MSDSs, descriptions of process and floor plans. These may not always be available and they may not always be relevant to an individual.

- Literature. This means of collecting information is often overlooked. Journals, text books, dictionaries, data banks and data bases are just a few of the useful sources. It is scattered through many fields. He noted the existence of MESU (by the Ontario MOL).

For the evaluation/semiquantitative assessment, he emphasized the importance of one person (or a panel) looking at all the information together, and that the individual(s) should have a good knowledge of industrial hygiene. The pieces of information are complimentary and should all be reviewed when some are missing or less clear.

The 'ouput' should include: **confidence** that an exposure has occurred and this can be graded as certain, probable, possible or unlikely (this may cover a variety of substances that cause the 'given' effect) and **level** and **frequency** of exposure. Route of exposure is important to consider. He emphasized that there is a lot of judgement needed to make such assessments and that with imperfect data, personal assessments will be different.

Comment - John Oudyke[1]

John Oudyk explained that he had prepared his comments before knowing what Michel was going to say, however he considered that his comments followed well. He talked about 'how an industrial hygienist does what is needed to assess exposure'. He used the example of an exposure profile performed for the purpose of workers' compensation.

There may or may not be access to the workplace, so there may or may not be the opportunity to obtain records or present measurements. Information sought through interviews:

- description of work activities;
- materials used, likely exposures, physical state;
- processes - engineering designs and methods used;
- labelling;
- type and duration of exposures;
- history of breakdowns, spills, maintenance;
- anecdotal eg descriptions of industrial hygiene practices, housekeeping, etc;
- any symptoms.

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[1] John provided Penny Chan with a document he prepared following the presentation: Individual Retrospective Exposure Assessments for Compensation Purposes. Anyone wanting a copy, please contact Penny or John Oudyke.

Other information sought through 'documentation' includes:

- if possible, industrial hygiene records: internal, MOL, and sometimes MOE records will be useful;
- physical plans, engineering design, etc;
  (mass balance studies can be performed using data on consumption rates, inputs, ventilation, air currents/flow diagrams, etc. Estimates from such calculations are compared to exposure records.)
- literature: NIOSH, industrial hygiene literature (information/manuals and recent journal publications), toxicological data (animal studies, risk assessments, etc);
- pharmacokinetic modelling. These take into account the possible types/routes of exposure, eg dermal, inhalation, etc, and the physical state of the substances. The later involves considering various forms eg vapour could be inhaled as such, or condensed on dust particles and inhaled. (This will affect the particle size, therefore the distribution and location in the lung - editorial comment)
- information from suppliers.

Other information that may be sought:

- Information from groups of workers in the same environment;
- medical/biological monitoring to determine/assess the body burden of a particular substance. This may be of particular importance for chronic exposures. It should be noted that these will also depend on the half-life of the substance and the form of the substance in the body;
- all information on the type of exposure to the substance including the route, degree, frequency, nature (eg continuous, peaks, etc), total duration...
- health effects.

He went on to describe the problems that are encountered in making the overall assessment:

- allowance for non-occupational exposures;
- incomplete data base (eg isolated reports, how much weight should be given to such 'data');
- industrial hygiene data have usually been collected for compliance purposes, or to assess the worst-case scenarios (for the purpose of determining the best method for protection). Such data are rarely adequate to determine average exposures;
- variation within a workplace as well as from day to day;
- extrapolating absorption rates from exposure data. There is personal variation and, among other things, absorption depends on physical form and solubility;
- technical problems may cause the important issues to be overlooked;
- interpretation of industrial hygiene data. Reliance on TLVs for assessments. If no evidence of exposure then there is tendency to assume no exposure.

He recommended that:

- there be **protocols for detailed exposure evaluations and that there be the right of access to the information gathered;**
- **no evidence not be interpreted as no exposure** and that
- **TLVs not be used as criteria for determining "sufficient" exposure (for entitlement).**

Discussion

Questions and discussion following these presentations:

- whether or not there are criteria to compare assessments. If they rely on professional judgement, there will be tremendous variation in the final assessments depending on the individual biases (and the 'hoped for' result) of the assessors;
- difficulties obtaining data from companies;
- causative odds;
- absence of data on exposure being interpreted as no exposure.

Legal Panel

The decision to rearrange the agenda was precipitated by the fact that the sessions were running late and Professor Ison had to leave at noon.

Terence Ison commenced by noting that, when he was approached to talk, he expressed scepticism: it would only be a repeat of a number of previous endeavours. This led him to the important point in his presentation: If the issues have been identified on other occasions, why had they not been resolved? - Because the issues are inherent in the present system of WC. He maintains that **the present system rests on a false premise**, ie that you can distinguish between disabilities that result from employment and those that do not. Secondly the structure of the discussions is wrong. He considered **that a Royal Commission should be appointed to address the issues in a comprehensive fashion**[2]. A commission would be

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[2] "The people of this province, including workers and employers, are paying an enormous price for that refusal (to appoint a royal commission). What has happened instead is that we have had task forces, we have had consultants, we have had legislative committees, we have had all kinds of system change in policy departments at the Board and so on. We have far too many fingers in the pie for an efficient output."

necessary to review the whole system and this would require a commitment and a great concentration of effort at one time. He observed that all previous reports have been implemented. Then there has been a period for the system to settle down. (Unlike the present state of continuous change.)

With respect to the topic for the panel, he maintained that the law has no role in assessing work-relatedness. The legislation states that a disease is compensable if certain conditions (specified in the legislation) are satisfied, eg 'due to the nature of employment' or is a disability 'arising out of and in the course of employment'. This may or may not be work related. The words are very important and should not deviate from those in the Act, he suggested 'employment causation'.

The role of law is to ensure that the system is administered and adjudicated according to the Act, and that the medical input is legally relevant.

Problems arise due to the different language of lawyers and doctors. There are different notions of burdens and standards of proof, and different presumptions. He talked about the difference between evidence and data. Data implies quantitative information, while evidence of exposure is also important. As an example he described the case of a worker in demolition, where there may be no measurements or perhaps records of substances. Information may be anecdotal. In law the determination is of the admissibility of the evidence and then weight. Decisions are on the weight of evidence. While in epidemiological studies conclusions are based on statistical significance. He described his interpretation of statistical significance. A threshold is implied. He talked of 'excess deaths' determined by SMRs and the importance that is placed on the role of chance.

Scientists have the privilege of not coming to a conclusion and awaiting further data. Lawyers dissect the scientific input and identify the assumptions that have gone into the study and determine the admissibility, weight and standard of proof of the evidence. Scientists may discount data, while lawyers may consider it weak evidence. But lawyers have to make decisions using whatever evidence is available and this may be based on 'light-weight' evidence, but the evidence against the conclusion may be even lighter weight. They have to decide the best available hypothesis. It does not have to pass a threshold (of statistical significance).

He considered that there had been a great improvement in the Ontario system with the advent of the WCAT. It has brought decisions into accord with the terms of the Act. One of the advantages he cited was that now decisions are analyzed separately for medical opinion, non-medical facts and the legal criteria. These analyses bring the components of the decision-making to light. He considered that one function for the task force would be **to ensure that this approach is used for primary adjudication.** Another issue for the task force is the **terms of the Act, eg wording - 'industrial' to describe diseases for compensation; the distribution of the criteria of eligibility between the definition section and the operative sections of the Act.** He commented that once the etiological criteria are satisfied then it is

necessary to move to the consequential criteria of eligibility for compensation. Section 122, suffering from .... and being impaired by .....Are these supposed to be the same? He asked whether impairment of body function was intended to come into definition of disablement (?)

Philip Vachon claimed that Terence Ison had stolen his speech! He noted that no WCB claims are more difficult than those for industrial diseases. There is a mix of law and medical science. Diseases have a number of possible causes, some may not be associated with employment. They take years to develop. There are difficulties trying to go back 30 years to companies, which may no longer exist. Lots of problems and no magic solutions. The best that can be hoped for is **a system which, as much as possible, decreases the number of legitimate claims that are rejected and the number of 'not so legitimate' claims that are accepted.**

His ideas for assisting in adjudication included:

- **review the definition of 'industrial disease'.** He based the need on: a) workers' compensation and health and safety use different terminology, are they the same? should they be? b) Section 122 lists 4 categories, at least one could not be considered a 'disease'. He suggested a simplified, general, flexible definition - 2 categories: contracted out of or in the course of employment and characteristic to that occupation; and related to specific or particular risk of the work.
- **review and update (on a regular basis) Schedules III and IV.** He noted that conditions such as tendonitis (which in Quebec is the source of 1600 claims per year and costs $19 million) bursitis, repetitive strain injuries, hearing loss, vibration-induced conditions and conditions resulting from high and low temperatures, should have presumptions.
- **set up a committee of experts (medical, industrial hygiene, chemists, etc) to determine causal relationships.**

He stressed the importance of the separation of law and medicine. The adjudicator should investigate the facts and seek the input of medical advisers. **The roles of the adjudicator and medical adviser should be more clearly defined and restricted to their field of competence.** The adjudicators need to clearly identify the issues/questions put to the medical advisers. As an example he cited the Lung Diseases Board in Quebec whose opinion is binding on the CSST. The question was raised: How can an adjudicator with no knowledge of the medical issues overturn a medical opinion. He suggested that such a board not be restricted to lung diseases.

Katherine Lippel agreed with the basic comments of the previous two speakers. However, she pointed out that one of the fundamental problems was that **the function (for the compensation system) had not been defined.** The other issue she addressed was the interaction between law and medicine. She considered that they do not ask the same questions. They have different 'cultures': comparative and sociological. The issue is - compensation for disease, not determining disablement. The issue has become: Is it related to the employment? What is the cause? She considered that the issue should not be whether

there should be compensation but who should bear the cost. She noted that, in disease, whether or not there is a causal relationship is often based on probabilities, so the possible answers to the question 'Is there an employment connection?' are in the range 'Yes', 'I don't know' to 'no'. The problem is that when it is phrased 'Should there be compensation?' there are only two answers possible and the 'don't knows' tend to be considered as 'Nos'. She talked of civil liability law where issues are less political, the compensation cases are determined on a balance of probabilities, which is clearly 50% plus one certitude. (Lawyers like honesty but cannot always get at the truth and cannot sit around and wait for the truth, they have to make decisions about **what is more probable than not.)**

Dr Lippel described a case that she thought exemplified the issue of (the problem with) causative odds. A worker exposed to a carcinogen for slightly less time than the eligibility criteria. She questioned whether the issue was the chance that this worker contracted the disease (the individual has the disease), whether this individual was more susceptible (thin skull syndrome) or whether acceptable risk in such cases (worker already has the disease) is the 'acceptable' risk of getting compensation (or not).

Her recommendation was that people understand what they are doing. This is particularly important for the interaction of law, medicine and science in these issues.

Discussion

There was extensive discussion following these presentations.

- 'causative odds' It was noted that the concept is beginning to be seen in decision making. There were some negative comments about its use.
- The question was asked - What would/should be done if a person meets all the criteria for compensation but is one year short on exposure time? 5 years short? Where should the line be drawn? Should it be drawn? This led to a discussion about numbers/criteria and the fact that epidemiological studies do not determine what the P value means. Also discussed was the 'thin skull syndrome', ie some people are more susceptible than others to certain diseases such that they may develop the disease with less exposure (ie below the criteria). It has been agreed that the thin skull syndrome should not be considered in compensation (for injuries).
- acceptable risk and the 'numbers game'- probabilities and eligibility criteria are based on them (**It was thought more important to determine the best available hypothesis** about what caused the disease in the particular case, ie taking all factors into consideration - not relying on a number eg 19 years).
- legal language for adjudication: 'related', 'cause', probability, 50 + 1 as the burden proof. There appeared to be some misunderstanding about what a SMR of 200 meant and the concept of $P = 0.05$.
- A basic premise that, if you can't be sure whether the solution will help, you should be sure that it won't harm.
- medical and scientific people may not have a standard. Standards may vary according to the consequences and purposes for the decisions (eg the standard of proof may vary

if the purpose is the protection of workers, what is needed to determine that some corrective action should be taken, compared to the standard of proof that would be required before a scientific person would say that a particular substance caused or could cause a disease). However the consequences are compensation (or whether the public purse should pay the compensation). There is not only a difference in the standards according to purpose but also according to personal ideology. It was noted that, for epidemiological studies, the reliance was on statistical significance and this depends on many factors especially the size of the study.

- proportional compensation as a means of dealing with cases of scientific uncertainty. One comment was that such a system would cause an escalation of the costs of adjudication and would lead to administrative problems with possible interactions with other benefit schemes, UIC, CPP etc. Ison suggested that compensation be paid without reference to cost but that causative data could be used for fairer cost distribution.[3]
- The Workers' Compensation Board is an insurance body, not a scientific body. The standards are set so that the thresholds are low enough to include all the cases that are likely to be related to employment and high enough to exclude those that are not. It has to deal with social questions. The example of the goldminer's policy was cited. This is a case where there was sufficient data to determine that there was a significant difference in the incidence of disease between the cohorts and the general population. This was considered sufficient to develop policies for compensation (even though the SMR was 148).
- The question of what is needed to recognize multifactorial diseases without consideration of individual causality.
- Universal compensation systems, where employment cause is not the issue (social security or social insurance systems - the later would make the benefits earnings related). Workers also pay into some of the schemes elsewhere in the world. It was noted that moves towards this type of system would need a royal commission to look at cost, implications and interactions on other systems.

Medical Panel

Ernie Mastromatteo. He commenced his comments noting the difference between lawyers and doctors, eg the importance placed on a separation between a controlling body and a professional association. The main points he made were:

- **the need to identify the new 'Koch's postulates' for relating specific diseases to work.** (diagnosis, compatibility to work exposure and whether the work exposure is capable of producing this type of disease or injury). He referred to Bradford Hill postulates: disease occurs after exposure commenced, the greater the dose the greater the likelihood of getting the disease, biological plausibility, reproducible ...

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[3] Editorial comment: Presumably this is because you are dealing with groups for cost distribution, not specific cases.

- **there should be computerized records of monitoring data;**
- **the importance of updating the definition of industrial /occupational disease.** The interpretation by lawyers is important for the legislation;
- questioning the inflexibility of Schedule IV and the irrebuttable presumption. He considered that if diseases were to be added there needed to be provision for criteria which could allow cases that did not meet some basic standards not to be included;
- **the importance of guidelines and the role of independent academics in developing them and/or advising on particular effect - exposure relationships, then getting the stakeholders to have their political and economic input for the Board to then make the decisions.** The physician should not be the adjudicator;
- Areas that should be considered by the Board for policy formation include: multiple allergy syndrome and, possibly, organic brain syndrome.

Sol Sax. He based his comments on a pragmatic approach, ie the doctor dealing with a patient. He emphasized that medicine is an art not a science and many of the conclusions that a physician draws are based on feelings (having gathered all the pertinent information). He then went on to list all the information that should be sought. The categories were roughly grouped into: a good history; a physical examination and, if considered necessary for the individual case, tests. From this information the physician reaches a provisional diagnosis of the most likely scenario (as well as alternatives), eg whether it could be work-related. The next issue is whether the employment would be the primary cause or secondary/contributory. He then described in some detail the various steps that he, as a company doctor, would take to determine the likely cause of the condition. These included a tour of the workplace/worksite (with the worker), industrial hygiene monitoring, discussion with union and company health and safety representatives, supervisor ..... For multifactorial diseases, exposure data are particularly important (generally what is available would not meet rigorous standards required for epidemiological studies). He emphasized that it is **not the physician's role to decide whether it is work-related** and whether or not the condition should be compensated. That is the responsibility of the Board. However, he expressed concern at the expertise available to the WCB to make some very difficult decisions and the reliance on physicians. He suggested that there be **Centres of Excellence and panels of experts** that would discuss issues and reach consensus. He claimed that such a mechanism can reduce the influence of personal biases. To the question of what probability of the condition being work related would he submit a claim to the board, he responded 5%[4].

Michael Wills. He commenced by endorsing Sol Sax's comment that medicine is an art. (Life is short and the art is long to learn, the decision difficult and the opportunity is now.) He noted that the World Health Organization had defined occupational disease and that its definition is quite different from work- related disease. (The work-related disease is

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[4] This was when it should be submitted to the board. This is contrast to the decision by the board which should be when it is sufficiently likely that the condition is work related to entitle it to compensation.

multifactorial and work has contributed to it in part). He expressed concern at the line between making a decision now and the data gathering process which can go on and on, noting that in Ontario there is no reporting system for occupational diseases. He commented that physicians in the community are concerned with treatment. As they do not get paid until there has been a decision at the WCB, it is a disincentive for identifying a condition as possibly being work related. Physicians act as the gatekeepers in this system and they should not. Generally that is not their concern, nor their area of expertise. **The concept of work-related is very 'fluid' and the dynamic nature of it should always be taken into consideration.** As an example he described the case of vibration-induced disease, how initially it was considered as white finger disease. Then the probable association of peripheral sensory neuropathy was recognised, then musculo-skeletal connection and now there is evidence of an association with scleroderma. What next?

He also suggested that someone should consider looking for diseases and conditions which are related to the same types of processes, eg hearing loss for those presenting with white finger disease from continual use of power tools.

Discussion

In response to a question about significant contribution in multicausal diseases, Dr Sax questioned the meaning of 'significant', Is it 20%? more or less? There are no numbers for it. Should numbers be derived from the risk data? (even if they could). He talked of 'gut units' noting that there is not and cannot be consistency with such an approach. The physician should not decide that, generally they do not have all the information, their primary concern is with treatment. Following on from this the issue was raised "What factors does the doctor take into account in making that determination, or what influences his/her judgement/feeling? An example of an approach to classifying the degree of certainty that an agent is capable of causing a particular medical condition/disease was that used by IARC (International Agency of Research into Cancer). Group 1 are considered to have sufficient data (epidemiological studies) to indicate that they are carcinogens, Group 2A are considered to be probable carcinogens (perhaps a greater than 50% likelihood), while Group 2B are possible carcinogens and judgement needs to be used in interpreting information on such cases (eg, agent, exposure, duration...). This led to a discussion of radiation (for which the data are the best). There are tables of attributable risks for varying exposures with associated confidence limits. It was noted, however, that these are still changing and the confidence limits are so wide, there is a question of their usefulness.

Other Points Raised in Discussion Included:

- the need to look at the association of COLD and dust exposure. This was identified as an issue using an example of a non-smoker developing chronic lung disease. However this raised the point that if dust contributed to the condition for the non-smoker presumably it would also contribute to the condition in a smoker. It was suggested that the smoker may in fact be more susceptible to the effects of lung

irritants. It was noted that in cases where there are guidelines for compensation and a worker meets the criteria the issue of whether or not he was a smoker is irrelevant. However, if he does not meet the criteria, it would probably be taken into consideration. Should it?

- Sometimes there is confusion about which is being determined diagnosis or causation. In the case of lung cancer, the diagnosis may be clear but the cause is not. What is needed is a differential "causation" using a similar process as for a differential diagnosis. It was suggested that the reports include the factors that contributed to the decision and why as well as those that did not. Whether or not a claim (form 8, which is only diagnosis and injury oriented) is submitted, is the first and often the most significant decision. This is what makes the primary care physician a 'gatekeeper'.
- the importance of the host-agent-environment interaction
- the need to consider prevention
- cor pulmonale and the implications to compensation of 'industrial diseases' (It appears as though only 25% of cases are compensated - presumably (?) claims were not submitted for the other 75%)
- by definition, there is under-compensation of industrial disease (many of the causal links have not yet been identified so the diseases are not compensated). The question is how can this be rectified, ie before the data are collected. There is fear of over-compensation, what does this mean? The point was raised that, in the case of gold miners, the cases were readjudicated when the policy was changed. However this was the exception and still does not cover those that did not submit a claim.

As the discussion had covered most of the issues identified for discussion in the first two case studies, it was suggested that there be a short round table discussion of the third case.

Leigh West asked Andy King to chair the discussion.

Case 3

It was noted that this was really about consequences of entitlement. Personnel from the WCB considered that the case would not be controversial, as such a claim would be accepted (without question[5]). The worker still had the disease (even though there were no symptoms unless there was exposure). It was clarified that it is not considered to be a precursor under the definition of 'industrial disease' in the Act. The issue in this case was thought to be vocational rehabilitation, retraining, NEL and FEL, ie the need to replace lost earnings on a permanent basis. There was discussion about the factors that are considered and how the length of the worker's experience in the field is not an issue, but may be considered in the vocational rehab assessment.

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[5] This was contested by a labour representative who said that, in practice, there tended to be lots of questions about such cases.

This led to discussion of the way asthma is handled under the new provisions introduced in Bill 162 (allowing a separation of wage loss from the rating system of impairment under the AMA). The ability to earn is considered and replacement of the pre-injury earnings and future economic loss award are based on that - When there is a pre-existing condition, benefits are paid for the time and effects which are over and above the preemployment condition. There ;was discussion of the difficulty of diagnosis and the 'need' for a MC challenge (often not performed). The conditions may be quite different for irritants (compared with sensitizers). The majority of asthma claims are granted on the basis of aggravation of a preexisting condition. This led to an interesting question about the meaning of 'no-fault insurance'. What about people with a predisposition for certain conditions? This is distinct from a preexisting condition.

It was clarified that S122 allows compensation for cases where a worker is removed from work due to a precursor condition (not intended to cover cases of sensitivities). It was explained that the need to include precursor conditions in the definition of industrial disease had its origin in the provisions of the Designated Substance Regulations under the Occupational Health and Safety Act) requiring workers to be removed from exposure, eg to lead when blood lead levels reached a certain level (for preventing disease). Although the need for income replacement was not debated, there had been a question about whether it belonged in the Workers' Compensation Act under the definition of 'industrial disease'.

One point that was made in the discussion was "Don't give too much discretion to adjudicators in the case of uncertainty".

APPENDIX 4

Questionnaire Sent to Canadian Jurisdiction

QUESTIONNAIRE

GENERAL

1. **Is industrial disease or occupational disease defined in your legislation?**

2. **What is included? (which diseases?) e.g. does it include noise-induced hearing loss and repetitive strain injury?**

3. **Are there special provisions?**

4. **Can 'diseases' be included as 'disablements' or injuries'?**

5. **Do you have schedules for industrial diseases?**
   - **Must a disease be on the schedule to be compensated?**
   - **Does a presumption of work-relatedness attach to the scheduled diseases?**
   - **What is the nature of the presumption?**

6. Are there provisions for compensation for:
   - diseases which are aggravated by employment?
   - diseases where there is evidence of a preexisting condition?
   - precursor conditions that require a worker to be removed from work?

7. Please attach a summary of the legislation/regulations/policies that are relevant to industrial diseases.

STATISTICS

1. What proportion of the claims are for occupational diseases?

2. What is the cost (actual) of compensation benefits for industrial diseases? and what proportion of the total costs does this represent?

3. What is the average duration (lost time) for industrial disease claims?

4. How many are for fatalities?

5. What are the provisions and costs for dependents?

6. **Does your data collection system allow you to separate statistics for industrial diseases.**

7. **What proportion of the industrial disease claims are covered by specific guidelines?**

ADJUDICATION

1. **If you have schedules, how do diseases or processes get added?**
   - process (administrative and political)
   - what are the criteria? what degree of scientific certainty is required? Is it based on:
   - **SMR values?**
   - **weight of evidence?**
   - **reference to other jurisdictions? or other?**

2. **How is the schedule used in the adjudication process? How can schedules be rebutted in practice?**

3. **How is work-relatedness determined?**

4. **How much reliance is there on guidelines? What role does 'precedence' take?**

5. **What do you do about multicausal diseases (and/or 'diseases of every day life')?**
- what level/degree of workplace contribution is required?
   - **necessary**
   - **significant**
   - **predominant**

6. **Is there a special unit for industrial disease adjudication?**
How many staff are assigned to industrial disease policy issues, medical adjudication and administration?

7. **Who examines the relevant scientific data and how is it provided to the adjudicator?**

8. **Who is responsible for gathering information on work history, work exposure and diagnosis?**
Who puts this information together to determine work-relatedness?
If not the adjudicator,
   - **does the adjudicator have responsibility for the decision?**
   - **does the adjudicator have all the information?**
   - **does the adjudicator ever challenge the decision?**

9. **Do adjudicators have general guidelines for structuring the decision process for industrial diseases?**
Do the adjudicators have set questions they ask of physicians? (Can we have a copy if they do)
Are the forms for physicians different for industrial diseases?

10. **Which diseases/types of cases are a problem for your adjudicators? Why do you think these are problems?**

EXTERNAL ADVICE

1. **Do you have any external advisory bodies?**
   - **for help for individual cases?**
   - **for advice on policies?**
   - **for identifying industrial diseases?**

2. **Are there any employer, labour or professional groups that have a special interest in industrial diseases in your jurisdiction?**

APPENDIX 5

List of Participants and Synopsis of Interjurisdictional Meeting on Adjudication of Industrial Disease

Participants
at
INTERJURISDICTIONAL MEETING
on
ADJUDICATION OF INDUSTRIAL DISEASE

NAME	POSITION	AFFILIATION
John Wisocky	Executive Director	Association of WCBs of Canada
Lorraine Stockdale	Technical Consultant	WCB - Alberta
Rob Ingraham	Manager Special Claims Unit	WCB - British Columbia
Rob Campbell		WCB of Manitoba
Andrew Rauska	Acting Director Planning, Policy & Public Affairs	WCB of New Brunswick
Ken Burkimsher	Technical Manager Complex Case Unit Diseases	WCB of Ontario
Lynn Elinson	Manager of MODP	WCB of Ontario
Pierrette Boyer	Compensation Services	Labour Canada
Niki Carlan	Chair	IDSP Ontario
Madeline Meilleur	Manager WCB Liaison	Canada Post
Leigh West	**Chair**	**ODTF**
Andrew King	**Labour member**	**ODTF**
Roger Rickwood	**Employer member**	**ODTF**
David Muir	**Medical Adviser**	**ODTF**
Penny Chan	**Research Coordinator**	**ODTF**

Synopsis

of

Interjurisdictional Round Table Discussion

hosted by

OCCUPATIONAL DISEASE TASK FORCE

May, 7, 1992
Ramada Inn
35 Laurier Street
Hull, Quebec

Participants

- Task Force members and medical advisor
- representatives from WCBs (management of adjudication or policy dealing with occupational diseases) from Manitoba, Alberta, British Columbia, New Brunswick, Ontario and Labour Canada
- Chair of IDSP
- Association of WCBs

Agenda

- Background information on legislation, processes and practices for adjudication of occupational diseases from various Canadian jurisdiction:
  - collation of responses to ODTF questionnaire
  - policies, guidelines and regulations where applicable
- Introductions. Each participant described their position,specific concerns and issues for discussion.
- Discussion

Issues discussed included:

- How to determine work-relatedness? (where to draw the line): dominant cause (Manitoba), significant contribution (Ontario), What constitutes an occupational risk?
- how to account for lifestyle factors (in multicausal diseases): preexisting conditions, preexisting disabilities, employment as aggravation and the possibility of proportional compensation.
- Role of medical advice
- How much investigation can be warranted for an individual case? - Verification of exposures. Time delays
- Weight of evidence, threshold of evidence ('preponderance' proposed by NB)
- Presumptions and benefit of doubt provisions

- Role of precedence in individual cases, between provinces, internationally.
- Science and politics of identifying occupational disease.
- Fiscal responsibilities of WCBs and whether they should be run as businesses. Who are the clients?

Issues considered important to address:

- need to reduce political influence on policy development and adjudication
- need for policies and guidelines (to aid adjudicators and for information and consistency of approach) especially for conditions like stress and AIDS.
- need for interjurisdictional arrangements for compensating workers with diseases with long latencies and multijurisdictional work histories.
- national schemes: a scientific information base, possibly a national IDSP. A mechanism to enhance communication, for sharing experiences and to allow for the assessment of the impact of one jurisdiction's policies on other jurisdictions. A means of reducing inequities between federal workers in different provinces and/or between provinces.

APPENDIX 6

Summary of Responses to Questionnaire from Employers and Occupational Physicians

Summary of Responses from Occupational Physicians to QUESTIONNAIRE

		Yes	No	No Opinion
1.	**Do you think the statutory term "industrial disease" should be changed to "occupational disease"?**	42	2	3
	Reasons*. - Broader, not just industries (nearly all those that commented 22) - more accurate description (2) - less restrictive - (no reason to change if defined)			
2.	**Do you think the WCB's present approach to compensation for industrial diseases is fair?**	11	22	8
	Reasons for opinion. - should only be for employment related cases (6) - too generous, easy to take advantage of (4) - relies too much on family physician, need experts (2/3) - not suited for industrial disease (multicausal) (3/1) - too slow, political, adversarial (1/2/1) - WCAT/bureaucracy/inconsistent (2/1/1)			
3.	**Do you think that employers should have the responsibility to pay for the costs of occupationally related diseases?**	34	3	1
	- if proven employer related (dominant) (7) - worker should also pay portion (or society) (3/2) - need accountability (4) - not if worker negligent (2) - only if employer negligent - should be universal compensation			
4.	**Do you think that workers who develop disease as a result of employment are getting adequate compensation?**	19	5	13
	too much?	10	4	9
	too little?	1	5	3
	Reasons. - too much/too little (8) - inconsistent, arbitrary (5) - lack of incentive to return to work (3) - not easy (4)			

		Yes	No	No Opinion
5.	**Do you know/understand the criteria the adjudicators use in determining compensability?**	**19**	**21**	**0**
	Would you like to see these more clearly identified? (very few commented)	**40**	**1**	**1**

- should be more available (4)
- educational, only qualified MDs should examine (1/1)
- doctors should adjudicate

6. **How do you think the WCB should distinguish between diseases that result from employment and those that do not?**

- panel of experts/professional assessments (17/4)
- proven relationship/published data (8)
- published guidelines (4)
- must consider preexisting conditions/non work factors (3/2)
- examine workplace (3)
- not always possible - universal compensation (3)

Do you think the present system does a good job?	**10**	**27**	**5**

Reasons.

- OK under the circumstances (9)
- lack of knowledge/expertise of adjudicators (2/5)
- diseases multifactorial (3)
- too political/disease label arbitrary (2/3)
- too much investigation/argument over cause (2)
- gives BoD to workers/too generous (1/1)
- workplace not examined/employer cannot contest (1/1)

What changes do you think need to be made to improve this process?

- comprehensive compensation/disability (4)
- more and better training for adjudicators (4)
- keep scientific (3)
- restrict to schedule (3)
- guidelines/list of diseasses/meat chart (3/1/1)
- clarify philosophy/ total review (2/1)
- better advice to physicians (2)
- better past medical history (2)
- limit appeals (2)
- cut down investigation/ involve E more (1/1)
- more restrictive/ W pay half (1/1)

		Yes	No	No Opinion
7.	**Do you think it is the role of the WCB to investigate and identify new industrial diseases**?**	**20**	**24**	**0**
	the role of an independent scientific body?	**38**	**2**	**0**
	a bipartite body (management and labour) external and independent of the WCB?	**15**	**19**	**2**

Reasons.

- needs to be independent (8)
- different groups should/can contribute differently (8)
- L & M too political have their own agendas (5)
- Ministry of Labour/integrate with OH&S (2)
- WCB with other stakeholders (scientifice not L & M)
- Labour rejects science
- not negotiable
- L & M would be fairer/WCB has conflict of interest
- WCB pays costs
- whatever no post lobbying

8. **How should the WCB compensate for diseases that are known to have a number of causes some of which are related to employment and others which are not?**

- criteria and proportional compensation (9)
- good guidelines based on epi studies (8)
- each on own merit (main cause) (3)
- impossible use comprehensive disability (2)
- SIF and remove from NEER (2)

What should be the determining factor***				
-	**more likely than not to be caused by employment?**	**24**	**5**	**0**
-	**probably caused by employment?**	**12**	**8**	**1**
-	**Possibly caused by employment?**	**2**	**16**	**0**

How should this determination be made?

- independent body (9)
- weighing workplace contribution ((9)
- majority of information/evidence (5)
- beyond reasonable doubt (causality shown) (3)
- science (not law) (3)
- physicians (2)

		Yes	No	No Opinion
9.	**Do you think a schedule of diseases where there is a presumption of cause from employment is useful?**	33	10	1

Reasons.
- should not <u>all</u> have presumption (need criteria) (8)
- help physicians (help screening) (6)
- should be available (4)
- only if based on science (3)
- very few (only when only cause) (3)
- too rigid (3)
- promote short cuts/assign blame (3)
- affected parties should be put on notice (2)
- for research

10.	**Should the provisions for determining compensability of diseases be different from those for injury by accident or disablements?**	18	19	5

Reasons.
- should be consistent, same issues (6)
- should be assessed by causality/proportional (4/2)
- diseases more subtle/not clear cut (4)
- different, latency, long term effects/prognosis & rehab (3/1)
- arbitrary, too easy to appeal
- universal compensation
- multicausal/need to account for individual susceptibility (1/1)

11.	**Do you think the proposals contained in the Board's discussion paper on entitlement should apply to industrial disease?**	11	5	25

Reasons for opinion. (large proportion not familiar with paper)
- needs to be assessed according to cause (not location) (2)
- too vague, all diseases <u>could</u> have relationship (2)
- need to consider cost/fiscal responsibility
- overstep responsibility of WCB
- based on disability
- arbitrary, should be based on facts

Will this affect you?	2	8	12

Comment:

		Yes	No	No Opinion
12.	**What do you see as the problems with the present system of adjudication of industrial disease claims?**			

- inconsistent/arbitrary/too easy to appeal (6)
- too slow/too much paperwork (5/1)
- poorly trained adjudicators/insufficient science (6/2)
- investigations difficult/conflicting opinions of specialists (2/1)
- needs to be more open (to doctors) (3)
- based on disability/not thorough disability (2/1)
- need to consider lifestyle
- level of proof too high/mistrust/too litigious/no standards

13.	**Do you have any experience with the systems in other jurisdictions?**	11	31	1
	Do you think that they work better than those in Ontario?	6	9	14

Reasons for opinion.

- US worse adversarial (2)
- PEI better - proactive
- British, Australian & NZ better
- Dutch, German about the same
- Saskatchewan no better
- no WCB workers more responsible more incentive to return to work

14. **Are there any amendments to the legislation that you think would improve the system for adjudicating and compensating for industrial/occupational diseases?**

- Act OK but not administration (3)
- better policies and guidelines/more standards (3/1)
- complete review of system required (2)
- should not be presumption based on (location) (2)
- need federal application
- repeal s 21
- section on non occupational diseases
- independent physician teams
- adjudicators need more information
- longer qualifying times

15. **Can you make any other suggestions for improving the system?**

- separate from politics (3)
- evaluate all diseases at centreal level (2)
- emphasize rehab and reassessment (2)
- make process open (2)
- increased accountability for WCB
- Use Act better
- needs to be fairer
- forget stress
- drop bomb on WCB

		Yes	No	No Opinion
16.	**Do you think that there are alternative mechanisms to compensation that should be considered? (eg private insurance, long term disability? comprehensive disability insurance? or...)**	**25**	**5**	**3**

- long term disability (8)
- comprehensive disability/both W & M pay (6/2)
- private insurance (6)
- social security (2)
- prorated on probability/fixed sum for disability (1/1)

How do you suggest they interact?

Please indicate how you think an alternative mechanism could improve compensation for workers' industrial diseases.

- fairer process (4)
- avoid disputes and ensure compensation (2)
- decrease hassles (2)
- E not penalized for W's personal habits
- help avoid 'horsetrading'

17. **Please indicate any other concerns:**

- System subject to abuse (2)
- need preventive measures
- need to comply with early rehab and modified duties
- should be funded from taxes (as much as sociey wants)
- systems probably too expensive
- WCB should aim to be fair and scientifically correct
- longer waiting periods and less benefits cuts abuse but penalizes injured workers (can this be politically acceptable to anyone?)

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* the comments and reasons are paraphrased, summarized and grouped. The numbers in brackets refer to the number of responses that contained a similar comment.

** Not surprisingly the majority of OP think scientific groups should investigate and identify OD. However the opinions about the involvement of WCB and L & M bipartite groups varied dramatically.
18 were of the opinion that no other should be involved
7 thought WCB should also be involved
10 thought all shoulf be involved
4 thought that M & L should be involved but not WCB
while 7 did not think science should determine
3 thought it should be WCB alone
2 thought L & M
1 thought WCB and L & M, and
1 thought that it should be the MOL

* ** Of the 24 who answered **Yes to 1**
10 did not mark any other alternative
5 answered 'No' to other alternatives
6 also answered **'Yes' to 2** (5 were 'No' to 3, 1 did not mark 3)
2 could not decide about 2 but said 'No' to 3
5 answered **Yes to 2** only (3 did not mark 1&3, 2 marked 'No' to 1&3)
Of the 2 that answered **Yes to 3** only(1 did not mark 2&3, 1 marked'No' for 2&3)
Only one respondent answered **Yes to 2 &3** and 'No' to 1

Summary of Employer Responses to QUESTIONNAIRE

		Yes	No	No Opinion
1.	**Do you think the statutory term "industrial disease" should be changed to "occupational disease"?**	28	7	6

Reasons*.

- occupational more appropriate/less restrictive (industrial obsolete) (18)
- neither appropriate/eliminate/no such thing (2)
- only definition important (3)
- would expand it more (4)
- industrial too general (2)
- need direct relationship to occupation

2.	**Do you think the WCB's present approach to compensation for industrial diseases is fair?**	5	22	12

Reasons for opinion.

- does not account for lifestyle (10)
- needs to be more scientific/speculative evidence from physician (3/1)
- unfair to compensate for possible/alleged symptoms/too broad (2/1/1)
- standards vary/no proper investigation (3/2)
- unfair to those that don't have access/need W accountability
- apportioning responsibility unfair (last E) (1/1)
- can appeal until accept (2)
- reasonable

3.	**Do you think that employers should have the responsibility to pay for the costs of occupationally related diseases?**	29	11	

- only for occupationally-related/proven work-related (overriding) (3/6)
- for probable relationship/and E could prevent (5/3)
- non-work related must be considered/adjusted for/ruled out (4/2/1)
- should be shared (3)
- not if worker informed of risks
- not if triggered by employment
- only for specific substances
- on the balance of probabilities

		Yes	No	No Opinion
4.	**Do you think that workers who develop disease as a result of employment are getting adequate compensation?**	**21**	**1**	**10**
	too much?	**9**	**4**	**8**
	too little?	**0**	**3**	**7**

Reasons.

- depends/some over some under (5/3)
- too generous/against return to work (4/5)
- must bear/proven direct relationship to work (2/1)
- only for loss of income (3)
- too expensive/needs review/same as injury
  WCB's discretion/doctor driven/W should contribute
- should be more alternate work
- retired W should not get same benefits

5.	**Do you know/understand the criteria the adjudicators use in determining compensability?**	**9**	**31**	**2**
	Would you like to see these more clearly identified?	**40**	**1**	**1**

- do adjudicators know? (5)
- need to be justified/simple (3/1)
- appears no standards/need consistency (2/2)
- only one criteria 'reporting'/beyond original intent
- must be due to nature of employment
- need more trust
- understanding from manual incomplete

6. **How do you think the WCB should distinguish between diseases that result from employment and those that do not?**

- medical/scientific proof/investigation (7/11)
- proven relationship (beyond doubt) (8)
- more testing/monitoring/investigation (6/4)
- clearly defined test (3)
- must take account of non-work related factors/ investigate personal history and fitness (7/3)
- W should demonstrate probable relationship (3)
- not always possible
- decided by a bipartite body

	Yes	No	No Opinion
Do you think the present system does a good job?	**4**	**23**	**5**

Reasons.

- slanted to favour W (8)
- too expensive (5)
- bending the law (5)
- haphazard (2)
- too many appeals, too many advisors (2)
- reporting only criteria
- no onus on W for prevention
- better than injury

What changes do you think need to be made to improve this process?

- more testing/monitoring - adjudicators rely on evidence of adequate exposure /speed system of MOL investigations (6/1/1)
- make it more understandable to adjudicators/ make it clear/simple (3/2/1)
- W should share cost - be accountable/ to reduce abuse /if not occupational (4/2/1)
- publicly funded CDI (2)
- proportional compensation (2)
- improve interface between WCB & WCAT/E (2/1)
- penalize abusers (2)
- share studies and standards internationally
- remove from politics/administration (1/1)
- no schedule
- educate MDs/adjudicators/independent medical review

7. **Do you think it is the role of the WCB to investigate and identify new industrial diseases**?**	**7**	**23**	**1**
the role of an independent scientific body?	**25**	**3**	**2**
a bipartite body (management and labour) external and independent of the WCB?	**15**	**13**	**1**

Reasons.

- too political (11)
- really scientific (9)
- M & L have the knowledge (6)
- objectivity leads to credibility (5)
- WCB should (only) provide information & statistics (4)
- all (linked) (4)
- WCB insufficient network/biased/too much bureacracy (1/1/1)
- not WCAT (2)
- should not be special interest/MOL & science (1/1)
- multidisciplinary/science with socially conscious review/advisory

		Yes	No	No Opinion
8.	**How should the WCB compensate for diseases that are known to have a number of causes some of which are related to employment and others which are not?**			

- prorating (15)
- should not compensate (6)
- worker contribute (3)

What should be the determining factor***

-	**more likely than not to be caused by employment?**	**20**	**11**	**1**
-	**probably caused by employment?**	**13**	**11**	**1**
-	**Possibly caused by employment?**	**3**	**21**	**2**

How should this determination be made?

- (if multifactorial) convincing evidence of cause (10)
- but must be proven (beyond doubt) (7)
- evaluate non work factors (4)
- by qualified independent politically untainted tryers of fact (legal)/multidisciplinary panel (4/1)
- adjudicators and MDs should visit & inspect workplace/ get more medical opinions (3/2)
- not easy (3)
- weigh evidence/significant contribution (3/1)
- onus on W to demonstrate on balance of evidence (2)
- international/national studies

9.	**Do you think a schedule of diseases where there is a presumption of cause from employment is useful?**	**22**	**16**	**1**

Reasons.

- should be no presumption/ no irrebutable (8/2)
- in some cases (5)
- for education/help prevention (5/1)
- when scientific proof (4)
- speeds process/reduce costs/consistencey (4/3)
- broaden scope of compensation (4)
- case-by-case (4)
- guidelines substantiated by medical evidence (2)
- only when agreed by bipartite group
- qualified by exposure criteria
- not unless a schedule for non work-related/ do not treat all E the same
- present form outdated

		Yes	No	No opinion
10.	**Should the provisions for determining compensability of diseases be different from those for injury by accident or disablements?**	24	13	4

Reasons.

- disease process different/presumption inappropriate (6/2)
- all involve disability -decisions on continuum (6)
- difficult to determine (6)
- get more medical opinions -sanctioned measurement (4)
- change system/CDI/funding include W and society (3/2/2)
- NEL & FEL different
- no benefit of doubt
- alternative should be ensured/significant contribution sufficient/prorating

11.	**Do you think the proposals contained in the Board's discussion paper on entitlement should apply to industrial disease?**	2	18	20

Reasons for opinion.

- object to presumption (4)
- do not agree with discussion paper (3)
- broaden scope/consider cost (2/1)
- process different
- puts onus on E to prove non work-related
- investigation and linkage by independent multidisciplinary panel
- tantamount to UD

Will this affect you?

12	1	7

Comment:

- start again or go bankrupt (3)
- I'm paying for this (2)
- work towards reducing causes, therefore costs

12. **What do you see as the problems with the present system of adjudication of industrial disease claims?**

- no ground rules/constant flux (6)
- biased to approving claims (6)
- basis should be science (6)
- poorly trained adjudicators/insufficient investigation (4/4)
- work load high/timeliness (3/3)
- provides coverage for which no premiums paid (3)
- E comments ignored/too much administration (2/2)
- impossible/difficult
- funding unfair
- political interference
- doctor driven

		Yes	No	No opinion
13.	**Do you have any experience with the systems in other jurisdictions?**	9	23	2
	Do you think that they work better than those in Ontario?	7	12	12

Reasons for opinion.

- must be better, not so debt ridden (3)
- reduced allowable benefits (3)
- more efficient and financially accountable (2)
- exclude chroneic multifactorial disease
- some basis for rebutting Schedule 4
- W responsibility for well being
- consider long term economy
- refunding to restore capitalization
- allows new diseases to be compensated

14. **Are there any amendments to the legislation that you think would improve the system for adjudicating and compensating for industrial/occupational diseases?**

- WCAT not determine compensible/abolish (4/1)
- more precise definition of what is compensible (4)
- UDI/change funding (2/1)
- make WCB/adjudicator accountable (2/1)
- seperate accident and illness (2)
- amend s134(8) to give rapid cost relief via SEIF
- system and guidelines clearer for adjudicators
- W accountable/onus on W/incentive for return to work
- legislation needed to initiate research

15. **Can you make any other suggestions for improving the system?**

- use specialized adjudicators (increase speed, consistency, knowledge and explain better) (4)
- make WCB more accountable/quality management (3/1)
- more investigations/enforcement (5/1)
- revert back to industrial accidents (3)
- use independent physicians (3)
- punish abusers (2)
- proof of work environment (2)
- review intent of benefits/check rate groups
- make process simple/streamline appeals
- use adjudicative tribunal
- national body to investigate ID
- exchange with people with business experience

		Yes	No	No opinion
16.	**Do you think that there are alternative mechanisms to compensation that should be considered? (eg private insurance, long term disability? comprehensive disability insurance? or...)**	23	4	4

- private disability coverage (12)
- CDI should replace all (11)
- supplement with LTD or private insurance (3)
- revamp present/make only for temporary (1/1)
- for schedule 2 only
- best in world preserve
- UDI expensive

How do you suggest they interact?

- equivalent bnefits (lower than now) (2)
- W should contribute (4)
- benefits not additive
- obligations and responsibilities to both E & W, do not compensate W that do not comply (2)
- eliminate WCB (2)
- create rate group fund for ID

Please indicate how you think an alternative mechanism could improve compensation for workers' industrial diseases.

- other benefits may reduce administrative costs/more closely monitored/cheaper (3/3)
- better faster coverage/ would not have to prove w-r/ less adversarial (2/1/2)
- alternatives keep government competitive (2)
- E not paying for non w-r (2)

17. **Please indicate any other concerns:**

- WCAT not accountable (3)
- do not compensate stress (3)
- punish abusers (2)
- make accountable - remove bureaucracy
- need cost benefit analysis
- concern at compensating effects of lifestyle and social factors
- present benefits do not provide incentive to return to work/make W accountable
- need more consultation for change
- system too complex
- stop talking and start doing
- change puts people out of jobs

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* the comments and reasons are paraphrased, summarized and grouped. The numbers in brackets refer to the number of responses that contained a similar comment.

** Of the 29 that wanted a scientific body 18 wanted only a scientific body, 6 wanted science and bipartite and 3 thought all should be involved. Only 2 wanted science and WCB. Seven wanted only bipartite group. Only 4 thought that only the WCB should be involved.

*** Eight did not respond to any alternative. Four responded NO to all. Thirteen thought only 'more likely than not'. Six thought 'probably', while only 2 said only 'possibly'.

APPENDIX 7

List of People Contacted

Groups and Associations Task Force Consulted

Employer Groups

Canadian Manufacturer's Association
Municipal Users' Group
COCA
Employers Council on Workers' Compensation
Employers Advocacy Council
Canadian Rubber Manufacturers Association
ORC: Environment, Health and Safety Group

Labour and Worker Groups

Ontario Federation of Labour
Occupational Health and Safety Committee
Workers Compensation Committee
Office of Worker Adviser
Occupational Health Clinics for Ontario Workers
Ontario Network of Injured Workers
Ontario Legal Clinics' Workers' Compensation Network

Individuals contacted

Workers' Compensation Board

Robert Stanbury
Stan Bucci

Consultation Unit
Jason Mandlowitz

Complex Case Unit- Diseases
Lenore Lecki
Ken Burkimsher
Karen Kines

Occupational Medical Consultant
Chandra Bilgi

Medical Occupational Disease Policy
Lyn Elinson
Cynthia Ledgley
Ka Shing Yeung

Corporate Data
Trevor Pounder
Bobbie Lee
Sylvia Rotolo

Stategic Policy Analysis Division
Linda Jolley
Paul Holyoke
Elizabeth Brown
Ian Welton

General Counsel, Legal Services
Gareth Perry

Ron Lovelock

Workplace Health and Safety Agency

Bob Maton
Cathi Carr
David Leitch

Ministry of Labour

Henry Turner
Ed McCloskey
Sandra Glasbeek
Gary Liss
John Wilson

Premier's Council

Nick Ignatief

Workers' Compensation Appeals Tribunal

Ron Ellis
Marie Makinson
Dan Revington

Office of the Employer Adviser

Jeffrey Stutz
Paul Gallino

Office of the Worker Adviser

Rosemary Tait

Ontario Workers' Compensation Institute

John Frank
Harry Shannon

Industrial Disease Standards Panel

Niki Carlan
Michael Wills
John McNamara
Bill Elliot
Jim Brophy
staff

Occupational Physicians

Lisa Doupe
Alice Dong
Sol Sax
Albert Ceccutti
Ernest Mastromatteo

Association of Workers' Compensation Boards

John Wisocky

Ministry of Health

Lesbia Smith

APPENDIX 8

Case Reviews

CASE REVIEWS

The decision was made to review some case records. The purpose was to trace the process, the information sought and factors influencing the decision of entitlement.

It was decided that cases would be chosen at random from a variety of categories. It was considered important to look at:

- different types of diseases
- some with policies some without
- a mixture of denied and accepted in the same category, and
- recent decisions.

The categories were chosen by reviewing a February 1992 printout from ODISS of claims registered in 1991. The categories chosen were not large such that a sample could be relatively representative. It is however important to point out that the cases were reviewed only to gain an understanding of the process and the types of issues an adjudicator has to deal with. The researcher was not reviewing the details of the claim for identification, the specifics of the information nor to draw conclusions about the decisions. Two broad disease categories were reviewed: Malignancies and Respiratory conditions. Within the malignancies, three groups were chosen according to causal agent:

1) solar radiation. This was chosen as there had been some confusion in the employer community about whether such claims were accepted and whether there was a policy.
2) sinter plant emissions. This was chosen as there is a clear policy and specific criteria are identified.
3) miscellaneous lung cancer. These were chosen to identify complex cases where the determination had to made about policies.

For respiratory conditions, it appeared as though sensitivities for isocyanates were relatively clear cut with a distinct policy. Therefore the group chosen was 'tight environment syndrome', a relatively newly recognized condition, where the etiology is largely unknown.

The following is a brief summary of impressions gained from scanning the information available in the files.

Malignancy

Causal agent - solar radiation (BEB)

According to the print-out received February, there had been 4 claims in 1991, 1 accepted, 2 pending and 1 rejected. A further specific search in June revealed 5 claims. These files were reviewed. Four were accepted and one was voluntarily withdrawn by the worker. The issue for the adjudicator appeared to be a diagnosis of a type of skin cancer which could be caused by sunlight and an occupation which involved considerable exposure eg road

construction (also exposure to coal tar), scaffolder, lineman and rodman in construction. All had exposure of over 17 years. The benefits were, at this stage, minor. However there was the advice to remove the workers from exposure and it was noted that multiple minor lesions are likely to recur. All had been treated and little time off work was involved. One worker was claiming for protective equipment. There appeared to be concern and possible appeals by (an?) employer on the grounds of non-work exposures (one worker was an avid fisherman).

Causal agent - sinter plant emissions (GUA)

According to the Feb print-out there were 11 claims, 3 accepted, 5 pending 3 rejected. Of those listed in the June print-out the first 5 cases were fatalities which were registered prior to 1991 but some of which had died in 1991. Some of these were not on the imaging system. Ten other cases (and one fatality) were listed. Two were listed as accepted, 4 were pending and 5 were rejected. Seven files were scanned: 5 accepted and 2 rejected (obviously a coding problem somewhere).

In these cases there appeared to be close adherence to the criteria in the policy, ie the duration and time of work at Pt Colbourne, Coppercliff refinery, Inco sinter plant. The diagnosis was lung cancer, age 57 to 87. Those rejected were workers that only worked in the smelter with no exposure to the sinter plant. Generally the workers were smokers and this was noted both in the medical and adjudication reports. The hygiene report on exposure was the critical issue and if not meeting the criteria, smoking and other alternative causes were mentioned.

Miscellaneous lung cancer

Twenty nine cases were initially selected at random. Twenty were fatalities. Many were old files where the worker had died recently (8, of which all but one were accepted). These were not scanned (not on imaging). A number were recent claims for recent deaths and were still pending (6). Ten claims were scanned, 2 of which were accepted. It is hard to generalize these claims. In many cases the workers had mixed work histories, often in mines, not always as miners or had not stayed in the mines. It seems as though a mining history is reason for submitting a claim. In most cases there were no policies to cover such histories and in some cases the worker did not quite meet the criteria for a number of different exposures. Little attention appeared to be paid, by either decision makers or advisers, to interactions, except in the case of smoking which often appeared to feature highly in the decision. Industrial hygiene reports and assessments were considered and in one notable case complicated mathematical calculations were used to determine relative risk on estimates of estimated exposures.

There was one interesting exception of a laboratory chemist suffering from kidney cancer where there was consideration of the potential for exposure to metal fumes, nitrates and organic solvents. This is an interesting and difficult case (which was rejected).

Respiratory

Causal agent - tight environment (BUMZ)

According to the February print-out there were 11 claims: 2 accepted, 1 pending and 8 rejected. June print-out recorded 19 claims: 6 accepted, 1 pending and 12 rejected. Ten were scanned: 5 accepted and 6 rejected (5 rejected and 1 withdrawn),

The presenting symptoms and diagnosis varied from bronchitis, mild allergy, breathing difficulties, asthma and respiratory irritation. Preexisting asthma was a consideration. Emphasis was on the hygiene reports as to whether there were contaminants found to be above exposure limits. The reasons for accepting cases seemed to be: if there were acute symptoms which resolved on removal (fume inhalation in intense heat); where there were several cases in one area, the employer had recently renovated and there were high mould counts (a situation acknowledged by the employer - 2 cases accepted and one withdrawn when the worker did not submit a claim); and when there had been co-worker support and previous reports of poor ventilation and other mild symptoms. One case of allergy to new carpet glue was allowed. Isolated incidents with no contaminants found or alternative, plausible causes tended to be rejected.

APPENDIX 9

Focus Group Meetings

Ministry of Labour
Steering Committee,
3.30 - 5.30 pm
November 20, 1992.
Minister's Board Room

Agencies
8.00 -10.00 am
November 23, 1992
Chestnut Park Hotel

Industrial Disease Standards Panel
Workplace Health & Safety Agency
Ontario Workers' Compensation Institute
Ministry of Labour (Special Studies)

WCB
11.00 - 1.30
November, 23, 1992

Vice Chair
Chair's Office
Medical Occupational Disease Policy
(MODP)
Strategic Policy Analysis Division (SPAD)
Complex Case Unit - Diseases (CCU-D)
Finance & Administration

Labour Groups
2.30 - 5.30 pm
November, 23, 1992

Management Groups
1.00 - 4.00 pm
November, 24, 1992

Ontario Workers' Clinics
11.00 -12.30
November, 26, 1992
Barrie

Ontario Medical Association
Section of Occupational and
Environmental Medicine
2.15 - 3.30 pm
December, 8, 1992

Employers Council on Workers'
Compensation
1.30 - 4.00 pm
December, 17, 1992

APPENDIX 10

Open Forum: List of Participants & Summary

OPEN FORUM

9.30 am to 4.30 pm January 14, 1993

Delta Chelsea Inn

Name	Affiliation
Leigh West	Task force, chair
Roger Rickwood	task force, employer member
Andrew King	task force, labour member
Penny Chan	research coordinator
David Muir (pm)	medical advisor
Bruno Rea	MOL
Ed McCloskey (pm)	OH&S, policy
Sam Guirguis (pm)	Special studies
Niki Carlan	IDSP
Bob Stanbury (am)	E rep, BOD, WCB
Rema Nestereiczyk	Chair's office
Linda Jolley (am)	VP policy
Barbara Whylie	Chief MO
Ken Paisley	medical resources
Lyn Elinson	MODP
Clair Marie Fortin	MODP
Ian Welton (am)	revenue policy
Lenore Lecky (pm)	CCU-D
Chandra Bilgi (pm)	OMC
Ken Burkimsher (pm)	CCU-D
Bob Maton	WHSAgency
Harry Shannon (pm)	OWCI
John Rideout (pm)	
Jeffrey Stutz	OEA

Lisa Doupe	Ont. Medical Association and GM
Sol Sax (am)	OSOEM and Dupont
Earnie Mastromatteo	CBOM and CMA
Albert Ceccutti	OMA and Falconbridge
Ian Howcroft (am) Maria Marchese (pm)	CMA
Steve Cryne	OEA
John Blogg	OMA
Joy McGuire (am)	Business Council on OH & S
Judith Andrew	CFIB
Ted Nixon (am)	W. Mercer LTD
Bruce Neville	The Wyatt company
Ralph Carnovale (am)	CUPE
Vern Edwards	OFL
Cathy Walker	CAW
John Perquin	USWA
Rosemary Tait	OWA
Jennifer Penney	Injured Workers Consultants
Karl Crevar	Ont Network of Injured Workers

Introduction

Leigh West welcomed everyone to the meeting and explained its purpose, noting that all have the same goal of wanting to improve the system such that it is fair, consistent, defensible and efficient - where the process is open and as non adversarial as possible. She noted that the task force was impressed by the comments already received and were looking forward to a fruitful discussion. She also pointed out that the task force were not given the mandate to change the system, however it was hoped that their work will set out options and provide useful background for further discussion in the future.

She introduced the task force and thanked them. The respect shown by the members and the way they have represented their communities has been the key to the progress of the task force.

Participants introduced themselves around the table.

1. FUNDING

The occupational physicians of the Ontario Medical Association had prepared a submission and Lisa Doupe introduced the other occupational physicians in attendance. She explained that the submission represented the views of the section on occupational and environmental medicine, but had not had time to go through the formal approval process of the OMA. She described the structure of the submission and then read the executive summary, which included:

- the endorsation of the need for a public inquiry into the compensation system
- that the recommendations of the task force represent a tinkering with a system which will
  - . increase cost to employers
  - . provide minimum benefit to injured workers
  - . detract from the need for a different system
- the need for a universal compensation system
  - . jointly funded by employers, workers, and government
  - . to deal with <u>any</u> disability
  - . to provide adequate health care, compensation and rehab benefits
  - . to be administered with restraints so that it does not provide disincentives for employers to remain in Ontario
  - . with an emphasis on incentives to employers, workers and unions to prevent accidents and promote early rehab
- specific issues are addressed in the submission and would be brought forward in the discussion as they arise.

Kathy Walker noted that it was a welcome introduction to the discussion on funding. She noted:

- the enormous concerns about cost
- the fear of the increase in costs thought to occur with expansion of definition of compensability
- that a royal commission should be to design a plan, not to determine the need for further study (the need has already been demonstrated
- labour does not want to put the issue of funding 'up front' (premature)
- the system should be universal and should include non wage earners. It should be 'state run'
- a scheme similar to New Zealand should be considered: funded by automobile insurance, employers and general revenue (for non-workers)[1]
- support for a scheme to include incentives to prevent accidents (eg OSHA and BC penalty assessments)

Discussion about the need for a public inquiry/Royal Commission included:

- it should produce results which lead to action (Some thought this more likely than others. It was noted that in workers' compensation the record of royal commissions precipitating changes in both legislation and administration had been good).
- labour supports a royal commission,
- it is an important issue therefore the study needs adequate funding and the profile of a royal commission (rather than a public inquiry)
- needs full power to call witnesses, summon bureaucrats, files etc
- needs to have a focus (this goes beyond workers' compensation and includes auto insurance, health, social services)
- should not look at a model, but investigate what is available and what is needed to solve the problems in rehabilitation and management of injured and ill workers (too much duplication, infighting...)
- Robert Stanbury spoke personally, not on behalf of the BOD, that, while supporting the concept of a thorough investigation or royal commission, such an investigation should not assume the result and should not be looking at specific models. It would need high quality people of high stature who are objective, respected and who will produce a report that will be credible. A royal commission would also be the best way of educating the public, especially the special publics most involved (the legislators). It will need the resources to understand all the issues: health and safety and disability. It should be open in who manages the system and how it is funded (who contributes and who benefits. "I think it is essential to have some high level public study")

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[1] There was brief discussion about NZ system, its problems but advantages over what used to be, noting that it does not cover all disease only occupational disease. It was suggested that, even with its problems, it was more cost efficient for a higher benefit level.

- support from, at least some, employers for the need for a fundamental review. The concerns are that: costs will be unacceptable (the belief is that at present the system is not economically sustainable); and, it would detract from the efforts to fix the present administration of the WCB. There is a short-term legislative agenda to help cost containment. Therefore the support from employers would be on the condition that the inquiry be simultaneous with not replace present initiatives, ie don't neglect short term initiatives while looking for long term solutions.
- support from CUPE for Royal Commission: it would not be likely to detract from current initiatives; should not assume the results; support universal funding for wage earners and non-wage earners, need to reduce duplication, needs powers of royal commission.

In response to a question, it was pointed out that the issues for physicians include; the need to provide incentives for prevention and rehabilitation at minimum cost; reduce duplication in administration (many large employers have dual 'compensation' systems: WC and private long term disability (LTD) plans). Private LTDs tend to move things faster, workers get payment faster, back to work faster (no need to assign 'blame' which decreases the adversarial relationships and delays). Disability is easy to assess but cause is difficult.

Bruce Neville commented that benefits under the WC system are very generous compared to any other scheme. This leads to pressure on WC system. WCB spends time determining whether the claim comes under their system as opposed to helping the injured worker (for illnesses, the delay may cause entitlement decisions to be made after the death of the worker). He considered that level of benefits should be considered. He also expressed concern that using the legal test of 'material contribution' or 'statistically significant increases in disease rates' could lead to the determination that anything could be included as related to work, eg the common cold. "There is a workplace contribution to just about all diseases" Statistics cannot tell cause, they can tell correlation, probability, incidents on groups not on individuals. This is the underlying issue. He went on to describe the history of 'industrial disease' (clear cut cases) and compared it to degenerative disc disease and lung cancer, ie multifactorial conditions. He expressed concern at the emphasis in the document in determining cause, whether or not work-related (only justifiable for the purposes of prevention).

The difference in level of benefits will determine which system gets the claims. He noted that if the levels are equivalent there could even be under-reporting to the WCB (due to the difficulties and delays at getting benefits). There is considerable overlap in the plans at present. If all were lumped together a higher benefit level could be provided for the sum of the various premiums (then the only issue would be whether or not there is a disability).

If the determination of cause is used to determine level or who should contribute to the funding (rather than who should receive the benefits) it would not solve the problem only shift the debate to a different forum.

It was pointed out that the underlying theme of 'fault' is tending to direct (perpetuate and confuse) the discussion on funding. For instance, in universal compensation, Should employers only contribute the proportion that is work related as they are not 'at fault'? or Should only certain employers pay? **Should we continue to assign costs (especially for industrial diseases) based on fault?** Is it economically sustainable? (declining industries) Is it possible (not knowing where the occupational diseases of today and tomorrow will be manifest? (It was considered unlikely to be associated with one 'industry')

Bruce Neville pointed out that the Act is only 'no fault' for workers not for employers. Employers wanted the costs to be assigned according to those incurring them. It was thought that this would be an incentive for reducing costs/preventing accidents.

This led to two discussions
1) flat rates/assessments
2) experience rating and the attempts to build this in as incentives (to promote safety?)

It was suggested that the focus on fault/cause tends to detract from the purpose - rehabilitation and compensation of the worker. As the reason for this focus and the pricing system was to provide incentives (ie both differential assessments and experience rating), both can only be justified (and all the work determining rates) if they lead to remedial action. It appears to be of no effect for occupational diseases. **Can you spread the costs in a fairer manner and provide incentives?**

It was noted that the discussion of universal compensation was beyond the scope of the task force. What is needed is a 'non-contentious means of spreading the cost more broadly while maintaining the fundamentals of the system. The system is supposed to be prefunded. However this can only work if the diseases incurred in the year can be estimated. As this is not possible there is logic for removing occupational disease from the system based on that approach. In that case how widely should the costs be spread: rate group, sector or total accident fund or outside the system? (It appears that, at present, it is the accident fund as each sector is already paying the maximum (or near) unfunded liability. Therefore, practically, the only question left is - Is there justification for having them payed for outside the WC system?

It was noted that at the ILO (working in close cooperation with the International Social Security Association) there is support for a level premium. It is believed that, otherwise, jobs with an inherently high risk are being unfairly/unevenly burdened. This need not detract from merit rating between industries. There was a recommendation that Schedules 1 and 2 be merged.

The difficulty of prorating cause between occupational and non-occupational factors was noted.

Judith Andrew thought the discussion of UC was beyond the mandate of the task force. CFIB considered that any discussion of UC is dealing with a long term issue where there is a lot to sort out. Therefore there is the need to address some of the crucial problems. The most important problem is that benefits are being paid out at a rate that is greater than is economically supportable. There is a huge unfunded liability and Ontario has the highest assessment rate in Canada. Until this is fixed there cannot be discussion of any expansion in the disease area (or universal compensation). She considered it very important to retain rate differentiation both from the OH&S incentives point as well as equity. Where cause can be attributed, it should be. Ontario is not an island and cannot deviate much from its competitors.

It was pointed out that in Ontario experience rating does not include OD claims.

John Blogg suggested that the task force look at the reports of Justice Rosch (?), 1950 and Justice Mcgilvrey (1967). These analyze the intent of the legislation. Relative to the funding of the system "Employers of today should not be required to pay for the benefits as a result of social justice ideals of the government or administration of the day". Relevant to OD, "It is unfair to visit on the share holders of 1950 a debt created in 1940". He suggested that just because science uncovers the cause of a disease in 1990 employers in 1990 should not have to pay for all those diseases (contracted in the past). Who should? Between 1914 and 1922 the consolidated revenue fund paid and he asked why now general revenue/public does not/should not pay. There are 3 parties: employers, workers and the public.

There was a lengthy discussion of various experience rating and penalty assessment programs, inspections and OH&S.

Roger Rickwood noted, as the employer representative on the task force, the issue of universal compensation was not within the mandate, however it is so fundamental that it is considered in the document and he appreciated the discussion that had occurred. He questioned the appropriate mechanism for study/inquiry, noting that several of the schemes that would be affected are federal. Therefore, if there were a Royal commission (though he was not yet convinced there should be), it would have to be joint Federal provincial. In the meantime the task force is challenged with making recommendations for improving the existing system. An alternative is an occupational disease fund. It appears that employers do not feel that they can pay any more into the system. For him a consideration for any proposed changes to the system is - Will they lead to additional costs and therefore how can they be funded? He referred to a proposal he had made a couple of years ago - that LTD schemes be mandatory for all employers in the province. LTD plans could be either state or private. He pointed out that 3% of claims are for occupational disease and, if there is a more liberal test (as in California), the claims may increase to about 7%. He did not think that the problems involved with compensating 3-7% warranted a totally new comprehensive scheme (too drastic a remedy for the problem).

He asked for discussion of the LTD proposal to deal with some of the hardship cases, noting that certain employer groups are strongly opposed to any such scheme that will cost any more money.

He thanked the participants for the discussion and suggestions, noting that the task force may only be able to list the options with pros and cons because it does not have the time or resources to analyze them and resolve the issue.

Steve Cryne noted that the discussion thus far had not really addressed the questions set out by the task force. Short of a major overhaul of the system, we have to deal within the present framework. How best to adjudicate the claims and how best to spread the costs within the current system. Within the Act S134(8) deals with the allocation of costs for industrial diseases and there are other sections, (not to unduly burden employers) which can be used as remedies. Other points he made included

- experience rating should be maintained.
- He disagreed with the proposal to include penalty assessments within the WCAct. The purpose of the WCAct is to provide benefits and rehabilitation to workers when disabled, and to collect assessments from employer community to fund those benefits. Enforcement should be done outside this system. Such a proposal would lose the focus of the system.
- He does not endorse a level premium
- a supplementary scheme is not appropriate.

2. POLICY FORMATION/IDSP STRUCTURE AND FUNCTION

Concern was expressed that the standard of proof for adjudicating occupational disease is 'balance of probability' while the standard of proof for policy development is higher: scientific proof and statistical significance. It appears that the occupational diseases which are contemplated for scheduling are 'sole cause'. The eligibility criteria which accompany diseases in policy manuals are developed on scientific evidence requiring a high probability of a causal relationship.

It was pointed out that most scientists would use the Bradford Hill criteria for assessing a causal relationship. Only one of the factors is statistical significance (even though it may be the only one that is 'visibly' being addressed by policy makers).
There are two issues: the underlying principles on which policy is developed and the process. The underlying principles determined by the policy makers, not the science, guide decision making.

Traditionally people have looked to epidemiology for the answers and within that an SMR of 2 has been considered a 'cut off'. However, practically this has not been the case. But, in accepting a lower SMR, criteria have been developed in an attempt to limit the number compensated to the 'excess'. Epidemiology was never intended to isolate a cause in individual cases, rather to identify patterns of disease in populations. Concern was expressed

that there are no consistent scientific measures used to direct policy development or legislation.

David Muir explained the origin of using an SMR of 2: 'on the balance of probabilities' meant that there had to be a greater than 50% (contribution by work) chance of being work related, and that is what an SMR of 200 indicates.

It was noted that policies established have relied on an interpretation of epidemiology, ie that by the studies you can determine the 'excess' that should be compensated. What about those people outside the group (criteria) who have the disease - How to adjudicate those claims? The system ultimately has to deliver benefits to individuals, however all the evidence comes from and applies to groups. Rarely, in practice, is SMR of 2 used. The test is a higher test and how can it be justified? (Because the information is more complex?) How to move the policy from being so restrictive to something that can help the adjudicator who has to make the decision.

It was suggested that policies are developed when there is some level of certainty that a disease in a worker exposed to certain occupational conditions would be caused by those conditions. However when there was not that level of certainty to develop a policy there could still be enough evidence at an individual level to meet the test of 'balance of probabilities' that the disease was related to work. Using the Bradford Hill approach can not lead to specific criteria, as often the data are not available or there are no clear cut answers. The balance of probabilities is a test for individual cases at the level of adjudication, however is not appropriate as a test for policy development. In policy development there is no knowledge of other factors that are affecting an individual which allow for a balancing of other hypotheses. Therefore a problem is that, when there is no policy, there should not be the assumption that the adjudicator could not determine that, for the individual, 'on the balance of probabilities', the disease is work related. In other words a lower standard of proof is needed at an individual level where other factors can factor into the decision.

When there is enough evidence it is easy to develop a policy. It is therefore unclear why more diseases have not been scheduled. The problem is for common diseases where it is next to impossible to meet all the criteria. These are the cases that need to be dealt with on a case by case basis. However concern was expressed that once these get to WCAT they become policy.

Ernie Mastromatteo stated that any decision about work relatedness is a scientific one and should be made by an independent scientific panel. The decision of compensability is political and should be made by the Board. He described examples which addressed the issue of cases which do not meet the criteria. His opinion was that these should be dealt with at the individual level.

It was suggested that the criteria should be used as inclusive with specifics to be considered for excluding cases, rather than the criteria being exclusionary.

Kathy Walker addressed the issue of elimination of waste/ duplication of effort. She considered that the IDSP should have the power to schedule diseases. The schedules should have conclusive presumptions, to eliminate uncertainty. She also noted that, due to the healthy worker effect, an SMR of 100 probably represents an excess of disease. If the IDSP has that power, it should be given the resources to do the research necessary.

David Muir clarified that SMRs only apply to the cohort of the particular study. He considered that the discussion was not addressing the issue of 'material contribution'. He maintained that there is no such thing, that it is a myth. If everyone is to be treated equally, then any contribution should be entitled to compensation. It was pointed out that arbitrarily drawing the line and dividing the population into two is also occurring between workers and non-workers. The question was then raised whether all miners that develop lung cancer should be compensated and once that decision is made, who should fund it.

The discussion was brought back to - What do you schedule, how do you determine it; then what are the indicators/criteria? How can they be useful to guide the adjudicators? rather than used as arbitrary means of dividing populations? You cannot rely only on epidemiological evidence. This is well recognized, both by scientific panels and in policy development.

Andy King asked how IDSP, as policy developers, can best get input from adjudicators to meet the needs of the WCB.

Lenore Lecky asked how IDSP sets priorities. This is important to determine the significance of the input from adjudicators. There also needs to be links to the front-line in determining how a policy will work in practice. The time frame is also important as adjudicators have to make decisions about injured or ill workers as soon as possible. They cannot wait years for a policy.

Niki Carlan explained that the IDSP has the authority to set its own priorities. Traditionally requests from the WCB have been addressed. However these have not always been shown to be as high priority for action as to deal with political issues. The things considered as determining priorities are: number of workers affected; other policies; concerns from unorganized workplaces; severity and incidence of the disease and, as at present the IDSP does not have research money, whether there is relevant literature. She also pointed out that Panel members have full time jobs and only make the commitment of 2 days a month to the panel. The past year and half have been largely finishing up the work of the previous panel. With respect to liaison with the WCB, she noted that, recently, they have set up joint committees with the WCB to look at issues/recommendations arising from the work of the Panel.

There was concern at the political influence over policy development and agenda setting.

Roger Rickwood asked for comments on the structure and role of the IDSP, and its relationship to the BOD.

There was discussion about the origin of the IDSP - scientific adviser to the Board, but it was also noted that, at that time, there was no involvement of stakeholders. Albert Ceccutti expressed concern at the addition of further layers in the system. These layers are costing money and not solving the problems. He also endorsed Mastromatteo's comments about the need to get the public back as a stakeholder.

Judith Andrew considered it important to separate a scientific panel from the WCB. However the WCB should be responsible for the policy making and seeking the involvement of the stakeholders. There was discussion about how the line be drawn between science and interpretation for the purpose of policy development.

- Judith Andrew considered that only the scientific 'evidence' be presented to the Bd which would have staff advisers for policy development.
- Jennifer Penney expressed concern at the assumption that science can be separated from policy formation. Most of the scientists on a panel would be 'political creatures'. There are huge gaps in the information about even the best studied toxic substances. This means that interpretations have to be based on assumptions and leaps in logic. The interpretations are coloured by their affiliations, experiences, ideals and political position. That is not to say that science is not very important and has an important role to play. She considered that science and policy should be closely linked.
- (my interpretation) Judith tried to make a distinction between the 'doing' (and reporting which should include a description of the gaps and assumptions) and the 'interpretation' of science.
- Rosemary Tait considered that the policy development be at the IDSP and that there be some sort of 'marriage' between the stakeholders and the scientists.
- the BOD is bipartite and is developing processes for involving stakeholders,
- these issues are more complex than others, is very specialized and needs informed input. Most stakeholder's do not have the time nor expertise. Therefore there is a need for a specialized body to develop policy then the WCB should translate the policies for the adjudicators, so in a way the WCB would be a stakeholder at the IDSP (ie have to carry out the policies).
- Jeffrey Stutz noted that he was against the formation of a research institute. From the point of view of his staff, employer advisers, the IDSP has slipped off scientific neutrality or objectivity (both in the recommendations and the composition) and he considered that it would be even more political if the task force's recommendation is followed, therefore he spoke against the suggestion of bipartite members of the BOD of the WCB being on the Panel. He recommended against a body other than the BOD deciding policy. The IDSP should be as objective science advisers as possible.

- It was pointed out that BOD cannot do policy development, only make decisions. So if it is not the IDSP that develops the policy, it is done by WCB staff. It needs specialized expertise different from other policy areas of the WCB. It needs stakeholders and scientists (and lawyers) involved, participating and understanding the various needs and concerns. This is distinct from the need for quality assurance of the science that is being used as the basis for discussion in policy development.
- Jeffrey Stutz, agreed that the BOD cannot develop the policy, he considered though that just because things are not being done right at the WCB should not mean that function(s) should be taken out and done by another body(bodies). The system should be 'fixed' such that it is done right at the WCB. He endorsed Albert Ceccutti's point that part of the dysfunction comes from the bipartite composition of the BOD. This has led to paralysis of the institution. ? because there is no public interest group on the BOD. He considered that it would help to process/demand decisions from the bureaucracy.
- Niki Carlan noted that if the IDSP was not to develop policy it would require an amendment of the legislation.
- Lyn Elinson considered that the process of policy development involves interpreting the scientific information, talking to the stakeholders including the adjudicators, considering the legal implications, studying WCAT decisions and other jurisdictions. Once the process is identified, then the decision can be made which would be the best body to perform these functions.
- Rosemary Tait responded that because stakeholder input is essential throughout the process and because it is difficult to be an informed stakeholder in this complex area, the IDSP should develop policy.

3. Research Institute

Andy King introduced the topic by noting that the intent of the task force's recommendations is not to create another bureaucracy. It seemed to be the best way to rationalize the concerns about the research, ie duplication, quality control, no consistent mechanism for setting priorities. The suggestion arose from the need to bring the money together and focus the different interests into a mechanism where priorities could be set and scientific quality could be assessed/controlled.

Discussion included

- there are two possible models for reducing duplication and achieving the goals. 1) the research institute (government agency. 2) better coordination between the present government bodies. Considering the cons and pros.
- there was a question of where current OH research is occurring and who is funding it. It was thought that the universities and hospitals are the only ones currently doing 'basic research'. There is a need to fund research, coordinate it, set priorities and peer review both the studies and the results. It was pointed out that if the same body funded, determined priorities and did the research there would be a lot of 'self interest' research.

- Harry Shannon described the OWCI.
  - it has 3 senior scientists all on secondment from universities
  - independent from the WCB which funds it
  - has its own bipartite BOD which also includes members from the academic institutions, and.
  - a research advisory committee (RAC) composed of scientists with international reputations and are from outside the province.
  - to some extent determine their own priorities with the advise of the BOD and the RAC.

  He commented that researchers tend not to like to be limited by very targeted research. Traditionally compensation research (for policy development) is reactive. There needs to be the opportunity for proactive, investigative research, eg where work is going - psychosocial.

  With respect to the need for a centralized institute with a fixed location, he considered that it can work for a small group. He commented that the proposal outlined by the task force mixes a number of different functions: basic research; literature reviews and collating statistics as well as grants administration. He considered it would be a mistake to attempt to make the institute completely comprehensive for OH research for the province. He drew the analogy to the IRSST in Quebec and suggested that if that was the intention of the task force, then it should visit IRSST. His final concern was whether there was enough money available at present in the province to achieve all the functions identified**
- Niki Carlan expressed concern at too close liaison to universities as the 'publish or perish' mentality tends to mean that often the research performed does not meet the needs of the granting agency (or the stakeholders). There are issues that need research to help bodies like the IDSP to set their agendas. She cited the example of the 10% labour force study (the analysis of which will help in priority setting). In other words they need input into the priority setting and if the research institute is too autonomous this may not be possible.
- Ernie Mastomatteo noted that for many years he has supported the need for a NIOSH type agency in Ontario. He believes that it should be divorced from government. It should be independent and the IRSST model would be good. He endorsed the task force's recommendation.
- Would this include the money from the WHSAgency? Is there any money from Ministry of Health being devoted to OH research?
- John Rideout explained that the OWCI was established as a highly integrated model to help propel policy decisions for the WCB. He noted this as a difference from what was being proposed by the task force. He also pointed out that OWCI was a legal entity of the WCB which is a non profit non share capital corporation. He suggested that the legal implications of the proposed recommendations "cannot quite be contemplated by the task force because we are a separate legal entity".

4. Other Issues

Lisa Doupe addressed Recommendation #39. The occupational physicians do not think it is appropriate. Active practice in OM is not an issue in a discussion of work relatedness. Performance issues are an internal issue for the WCB and they questioned why only OMCs were seen to need such outside practice and not other technical people.

Andy King introduced the discussion of 'material' contribution, explaining that the task force had found that it is the test used by the court system in other jurisdictions and supported by the Supreme Court of Canada. He noted that the term 'significant contribution' was used by the WCAT and the tribunal maintained that it was equivalent to 'material contribution'. Therefore material contribution is the legal test, He questioned what other authority was there for any other interpretation.

This led to a discussion of what this means when science and medicine cannot answer the question of cause, and the fact that this was one of the driving forces for the call for a radicle change in the system. Points in this discussion included:

- workplace could be shown to contribute, to some degree, to almost any disease
- does this mean that all should be compensated? if so, How could they be paid for?
- the distinction between what is and what is not a 'material contribution' is arbitrary justice
- David Muir contended that the document and the case law fails to take into consideration the fact that diseases with multiple etiology are not caused by either A or B but A, B and other factors may all play a role in causation
- lawyers are not troubled by the interpretation of significant. It is justified by what is fair.
- physicians are, as they do not know what this means and how to determine the level. This is troubling to the physicians who care about the welfare of their patient and know the effect that being one side or the other of the arbitrary line will have.
- David Muir considered that, other than universal compensation, the only way to be fair would be proportional compensation to workers according to the proportion that the work contributed to the development of their disease.

In concluding the meeting Roger Rickwood noted that the issue of rehabilitation, although not discussed in the forum, has not been ignored. The task force recognizes the importance of effective rehabilitation and that there will be a recommendation that the WCB place special emphasis on it. He understands that the WCB has already an active program, however he thinks it of such importance to both employers and workers that the WCB should communicate more about its activities especially to employers.

Leigh West thanked all the attendees for their participation in the discussions and their other comments. It is hoped that the concerns raised will help the task force in its deliberations and to reach the best decisions on advice to the Minister. The report should be completed by the end of February and the hope is that it will lead to actions that will improve the system of adjudication of occupational disease claims.

KF 3615 ZB38 1993 c.1 WCAT
Report of the Occupational
Disease Task Force. --

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July 12/93	[illegible]
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